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ABSTRACT

THE FIRST STUDY CONCERNS THE EFFECTS OF LEVEL OF CLINICAL EXPERIENCE OF JUDGES ON RELIABILITY AND VALIDITY OF EXPERIENCING SCALE (EXP) RATINGS. INEXPERIENCED AND EXPERIENCED JUDGES RATED TAPE-SEGMENTS FROM PSYCHOTHERAPY SESSIONS. NO DIFFERENCES EXISTED BETWEEN RATINGS. THE SECOND STUDY FOCUSES ON THE RELATIONSHIPS OF IN-THERAPY PATIENT EXPERIENCING AS MEASURED BY THE EXP SCALE TO CASE OUTCOME, COMBINING A SAMPLE OF PSYCHONEUROTICS AND SCHIZOPHRENICS. EXP RATINGS MADE BY CLINICALLY NAIVE JUDGES FROM TAPES INDICATE THAT EXPERIENCING DIFFERENTIATES GROSS DIAGNOSTIC GROUPS, WITH PSYCHONEUROTICS ATTAINING DEEPER LEVELS. THE FINAL STUDY RELATES CONSTRUCT VALIDITY OF EXPERIENCING TO EYSENCK'S PERSONALITY DIMENSIONS OF NEUROTICISM AND EXTRAVERSION-INTROVERSION. NORMALS AND INDIVIDUALS APPLYING FOR PSYCHOTHERAPEUTIC SERVICES COMPLETED A QUESTIONNAIRE BATTERY AND THE GILBERT SELF-INTERVIEW. AN OPERATIONAL MEASURE OF EYSENCK'S TRAIT PERSONALITY CONSTRUCTS SEPARATED NORMAL AND PSYCHONEUROTIC SAMPLES IN A MANNER CONSISTENT WITH EYSENCK'S THEORY. TABLES, GRAPHS, REFERENCES, AND APPENDIX MATERIALS ARE INCLUDED. (EK)

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I. Introductory Section

A. Summary

The present studies continue a program of research regarding the client in-counseling behavior of Experiencing and its operational statement, the Experiencing Scale. The Experiencing construct evolved from the theoretical writings of Carl Rogers (1959, 1960) as well as from Gendlin's more recent elaboration of the construct (Gendlin, 1962). The Experiencing (EXP) Scale evolved from Roger's original psychotherapy process conception (Rogers, 1958, 1959) to its present form as a seven-point, annotated and anchored rating scale (Gendlin & Tomlinson, 1961; revised by Klein, Mathieu, & Kiesler, 1969) with standaridized training procedures for application to tape-recorded samples of the therapeutic interaction.

The present research incorporated three distinct studies. The first continued methodological sharpening of the EXP Scale by examining the effect of level of clinical experience of judges on the reliability and validity of EXP ratings. Two groups of judges, four experienced clinicians and four undergraduate students who were naive clinically, independently rated a sample of 42 tape-recorded segments from psychotherapy sessions of schizophrenic, psychoneurotic, and normal subjects. The results indicated that the two groups of judges' ratings were virtually indistinguishable. The interrater reliabilities, means and standard deviations of the naive vs experienced judges were equivalent, and the two sets of EXP ratings intercorrelated positively to the limits of their respective reliabilities. These findings indicate that efforts expended to anchor the EXP Scale with tape-recorded examples of the various scale stages, and to standardize a training procedure involving approximately 10-16 hours spread over time have yielded an assessment instrument that can be applied with good reliability and validity by judges of widely divergent experiential backgrounds. Importantly, it shows that clinical experience is neither necessary for, nor detrimental to, learning and applying the EXP Scale. This suggests further that the scale authors have indeed been successful in keeping the level of clinical or other inference required for EXP ratings at a minimum.

The second study focused on the relationship of in-therapy patient Experiencing as measured by the EXP Scale to subsequent case outcome. Although previous studies have established that deeper levels of Experiencing are associated with more successful outcomes, the findings were based on

small numbers of samples of the psychotherapy sessions. This second study took a more intensive look at in-therapy Experiencing by combining a relatively exhaustive sampling of a group of psychoneurotic patients in individual psychotherapy with the previously intensively sampled therapy sessions of hospitalized schizophrenic patients (Rogers, Gendlin, Kiesler, & Truax, 1967). EXP ratings were obtained on samples from each of the first thirty tape-recorded sessions for 14 schizophrenic and 26 psychoneurotic patients. This sampling provided an exhaustive coverage of the earlier phases of individual psychotherapy for these two groups of patients. Further, since it represents a period of approximately 8 months duration, on the average it samples exhaustively the majority of psychotherapy as traditionally practiced--orthodox analysis excepted. These EXP ratings were then related to independent measures of more vs less successful case outcome. Generally the findings solidified previous evidence for the validity of the Experiencing construct. Experiencing clearly differentiated the two diagnostic groups' level of functioning in therapy, with psychoneurotics attaining deeper levels than schizophrenics. Experiencing was strongly associated with more successful outcome for both schizophrenic and psychoneurotic cases. Level of Experiencing alone accounted for these relationships, suggesting that what is being measured by the Scale is more similar to an expressive trait, rather than a state or change variable. The data were clearly inconsistent with the notion that change or improvement in Experiencing is an important component of successful therapy, although alternate sampling procedures should be considered before this conclusion is accepted as final.

The last study attempted to extend the construct validity of Experiencing by relating it to the personality domain. The expectation of the study was that Eysenck's personality dimensions of neuroticism and extraversion-introversion (Eysenck, 1953, 1957) would be related to level of Experiencing manifested in a quasi-therapy situation. The latter was a self-interview situation where subjects talked about their problems, values, good and bad aspects and so on to a tape-recorder in a room by themselves. Samples of 88 introductory psychology undergraduate students and 68 undergraduate and graduate student clients applying for psychotherapeutic services at a University counseling service performed the self-interview task. Samples of their tape-recorded self-interviews were then extracted and rated for Experiencing by a group of judges. Interesting but somewhat

complex relationships were found for Eysenck's personality groups, particularly hysterics and dysthymics. The factors of sex and client-nonclient student status interacted significantly with the personality dimensions. Neither the neuroticism nor the extraversion-introversion factors alone was related to Experiencing. Generally the findings support Eysenck's interactive notion of personality factors, and clearly support the contention that factorial designs incorporating several independent variables are essential for tapping significant personality relationships, at least with in-therapy Experiencing.

B. Background for the Study

The disciplines of counseling and psychotherapy have exerted important influence on the field of education by assisting in modifying pedagogical technique in the pursuit of educational goals. This influence has more recently been accelerated with the development of behavior modification procedures many of which have clearcut and direct applications to classroom management. In light of this development it seems crucial that demonstrated knowledge of counseling and psychotherapy continue to increase so that educational applications of this knowledge can become continually more sophisticated, being based upon solid research data.

Currently our verified body of knowledge concerning counseling and psychotherapy leaves much to be desired. Although intensive and extensive research efforts have been made in the last two decades, our information about psychotherapy and behavior change remains quite limited. Still unanswered are basic questions such as: What are the therapist attitudes and/or techniques which facilitate client growth in therapy? Are particular techniques more beneficial for certain types of clients than for others? How does one define and measure the outcomes of psychotherapy? What is the psychological process by which, or through which, the client changes toward more adequate functioning in psychotherapy?

It seems clear that much of the difficulty in counseling and psychotherapy research has resulted from a tendency to ignore patient and therapist individual differences--to regard psychotherapy as a unitary, mysterious, idealized, homogeneous treatment appropriate and effective for all types of patients (Kiesler, 1966, 1969, 1970). Colby (1964) defines this presupposition as the "uniformity assumption"--the assumption that psychotherapy, as a treatment, represents a uniform, homogeneous process. Until our research designs incorporate relevant patient factors and crucial therapist individual differences variables--so that one can assess which therapist behaviors produce what kinds of change with which types of patients--we will continue to perpetuate confusion. Psychotherapy research must come to grips with the need for factorial designs as recommended two decades ago by Edwards and Cronbach (1952), so that one can begin to discover the parameters needed to fill in a meaningful paradigm for psychotherapy. The author has recently presented a Grid Model (1969, 1970) based on these differential assumptions as a guide to future theory and research in psychotherapy.

One goal of the present research, therefore, is to examine a patient in-counseling behavior, Rogers' Experiencing construct (Rogers, 1959, 1960; Gendlin, 1962), vis a vis the individual differences domains of patient pretherapy characteristics, and therapy outcome. Can clients be reliably differentiated in terms of the quality of their in-therapy verbal expressions? Is this intherapy behavior (Experiencing) related to success in counseling? Can this same within-the-interview behavior be related to personality theory? If the answers are yes, one has the possibility of more economic selection of clients for psychotherapy, for development of more specific counseling techniques for particular patients, and in the long run for extrapolation of these learnings to the classroom setting.

The Experiencing construct evolved from the theoretical writings of Carl Rogers (1957, 1960) and has been more extensively elaborated by Gendlin (1962). Its operational form, the Experiencing Scale, evolved from Rogers' original process conception (Rogers, 1958, 1959) to its present form as a seven-point, annotated and anchored rating scale (Gendlin & Tomlinson, 1962; revised by Klein, Mathieu, & Kiesler (1969)).

Rogers' concept of the fully functioning person postulates the emergence on one's personality through a process of progressive self-awareness. It is this process of increasing self-awareness, as evidenced by moment-to-moment Experiencing, that characterizes the patient's development during therapy. The Experiencing Scale attempts to measure the extent to which the patient's verbalizations reflect his ability to experience the full range of his feelings, and his awareness of the implications that his feelings and experiences have for him.

At the lowest stage of Experiencing the patient is not able to "own" his affective involvement in what he says, i.e. reveals nothing private about himself and does not acknowledge his feelings. This owning of his involvement in his narrative progresses until at the middle stages of the scale the patient is able to express freely his feelings and explore them in search of their personal meaning. The upper stages represent the patient's deep awareness of his feelings, successfully understanding them and integrating them into his experiential framework. At these latter stages he is able to arrive at conclusions based upon insight into the significance of his feelings, and has attained the freedom to move easily among his experiencing and its significance. (See Appendix A for a copy of the Experiencing Scale).

The present research continues a program of studies centered around the Experiencing Scale (Kiesler et al., 1964, 1965, 1967; Rogers et al., 1967; Ryan, 1966; Schoeninger, 1965; Schoeninger et al., 1967). To date the evidence suggests that patient Experiencing is related to success in Rogerian psychotherapy for both psychoneurotics and schizophrenics, and that this relationship is detectable even quite early in therapy. Generally, the Experiencing construct seems to have supporting construct validity, is becoming more scientifically sophisticated as methodological studies accrue, and although derived from a specific theory of therapy seem quite appropriately applicable to other formulations of patient therapeutic process.

In contrast, other psychotherapy process studies to date have been for the most part empirical in emphasis, with only limited efforts being derived from theoretical positions. Further, the instruments developed for measuring client process have been prolific (Auld & Murray, 1955; Gardner, 1964; Grossberg, 1964). Few have been applied on a large scale or persistently by investigators in the area. Rather it seems that psychotherapy researchers with some notable exceptions--Bordin and his colleagues (Bordin, 1948, 1955, 1963; Bordin et al., 1954; Harway et al., 1955; Raush et al., 1956), Howe & Pope (Howe, 1962a, 1962b; Howe & Pope, 1961a, 1961b, 1962), Saslow & Mararazzo (Saslow, 1954; Saslow et al., 1955, 1956a, 1956b, 1957; Matarazzo et al., 1956a, 1956b, 1956c, 1957, 1958a, 1958b), Strupp (1957a, 1957b, 1957c, 1958a, 1958b, 1962)--seem unmotivated to follow up their process measures with the kind of intensive and detailed research necessary to make one's instrument sophisticated enough for general research application.

The present research examines the Experiencing dimension further as a pretherapy and in-therapy attribute by continuing methodological sharpening of its operational form, the Experiencing Scale, by cross-validating on a larger sample of psychoneurotic subjects the relationship between level and change in Experiencing in therapy and eventual case outcome, and by attempting to relate Experiencing to the personality (individual differences) realm. If the predictions are upheld a counseling behavior, level of Experiencing, is identified which can reliably differentiate success and failure in therapy for diverse client and patient populations and which shows promise as a classification factor by which one can devise specific differential techniques. Further, if

Experiencing can be related to significant personality variables its construct validity is considerably extended, and the probability is good that in-therapy behavior and subsequent case outcome might be predicted from pre-therapy personality assessment.

II. Method, Results, and Discussions

The research reported below deals with three separate studies. The first continues previous methodological sharpening of the Experiencing Scale by examining the effects of level of clinical experience of judges on the reliability and validity of EXP ratings. The second study focuses on the relationship of in-therapy patient Experiencing to subsequent case outcome, by combining a relatively exhaustive sampling (first thirty interviews) of a group of psychoneurotic patients in individual psychotherapy with the previously intensively sampled therapy sessions of hospitalized schizophrenic patients (Rogers et al., 1967). The final study attempts to expand the construct validity of Experiencing by relating it to the personality domain, in particular to Eysenck's (1953, 1957) personality dimensions of neuroticism and extraversion-introversion.

This section of the report is organized accordingly, presenting each of the three separate studies in turn.

A. Comparison of Experiencing Scale Ratings of Naive vs Clinically Sophisticated Judges

When researchers are confronted with the mass of tape-recorded data which is often a concomitant of psychotherapy process studies they are simultaneously presented with the necessity of many sampling, unit size, and other methodological decisions before they can even begin to apply rating scales or other assessments to this data, or analyse it meaningfully in other ways. A detailed discussion of these basic methodological issues for psychotherapy process research has been presented elsewhere (Bordin et al, 1954; Kiesler 1966, 1970

This paper deals with one of these methodological considerations for the Experiencing Scale (Klein, Mathieu, & Kiesler, 1969), which is designed to measure one of the "strands" of Rogers' patient process conception (1958, 1959) and evolved from Gendlin's theoretical refinement of the Experiencing component of Rogers' conception (Gendlin, 1962) and from the earlier form of the Experiencing Scale (Gendlin & Tomlinson, 1961).

"Most generally the term Experiencing is meant to refer to the concrete, ongoing functioning of what is usually called experience, the basic felt datum of our inwardly focused attention. It includes our feelings of having experience, and the continuous stream of sensations, impressions, somatic events, feelings, reflexive awareness, and cognitive meaning that make up our phenomenological field. Experiencing is not simply a reenactment of events, but includes their personal felt significance. It is not just a set of concepts or logical operations, but refers to the inner referent used to anchor concepts. Also experiencing is not simply the experience of affect, self-conxciousness, or self-management. The term is meant to include the broader band of implicit and explicit meanings that structure sensations and feelings and articulate our sense of personal continuity by supplying the personal coloring of events and the personal significance of our reactions to them." (Klein et al., 1969).

"The lower levels of the Experiencing (EXP) Scale deal with the degree of direct inner reference apparent in the patient--the degree of his focusing on the subjective, personal meanings, and experiences of events and his reactions to them. At the higher levels the continuum considers more advanced kinds of focusing where the experiential perspective is transformed and used for exploration and problem resolution." (Klein et al., 1969).

A detailed review of the literature involving the Experiencing Scale can be found in a chapter of the Experiencing Scale Manual (Klein, et al., 1969) as well as in Rogers et al (1967). Considerable effort has been expended to date to resolve some of the basic methodological issues for the Experiencing Scale. Various problems such as optimal size (i.e. tape segment size) of the EXP process unit (Kiesler et al., 1964), appropriate location for extracting samples within the individual recorded session (Kiesler et al., 1965), potential confounding of EXP ratings by the degree of patient verbal productivity (amount of time talk) in the particular tape-segment (Kiesler et al., 1967), potential confounding of EXP due to the presence of therapist verbalizations on the tape samples (Schoeninger et al., 1967) have all been resolved for the EXP Scale. These findings indicate that the size of segmented samples can be either small or large (2-16 minutes) with no loss of reliability or validity, so long as the size is standardized for a particular study; that significantly different trends of EXP are present within the individual therapy sessions of different diagnostic groups, and that one must be careful how he samples location-wise (early, middle or late in the hour) particularly if his number of samples is small; and that EXP differentiations of diagnostic groups and outcomes is unaffected if the amount of time the patient talks in the tape-segment is statistically controlled by covariance analysis. Finally, interrater reliability of judges' EXP ratings has been good (Ebel intraclass coefficients range from .76 to .93 in previous studies) when at least three judges independently rate experimental tape-segments in random order, and the mean of the judges' ratings is used as the EXP score for a particular segment.

The present study deals with an additional methodological issue for the Experiencing Scale--the level of clinical experience needed before one can obtain valid as well as reliable EXP ratings from judges. Can clinically naive judges rate the Experiencing dimension as validly as experienced clinicians (or vice versa)? Does one obtain significantly different EXP values or reliabilities when groups of judges differ in terms of clinical sophistication? Since previous studies with the Experiencing Scale (Kiesler et al., 1964, 1965, 1966; Rogers et al., 1967; Schoeninger et al., 1967; Ryan, 1966) utilized naive, undergraduate judges almost exclusively this issue is quite important.

The majority of these raters were undergraduate students drawn from liberal arts departments, especially from English, Art, History, and Speech. According to several pilot studies students with these interests could be quickly trained to grasp the conceptual dimension basic to the Experiencing Scale and to apply this dimension reliably to the tape-recorded therapy interaction. Psychology students have not been used as raters on the assumption that their set for the rating task might be more biased in various ways than that of non-psychology students, although this assumption has not been empirically tested.

Naive judges were chosen in previous studies not only for economic reasons, but also since research evidence suggests that naive raters might be freer to adopt a set to rate the patient's observable behavior than would the expert clinician who, being trained to attune himself to the intent and motivation of the patient, might be more predisposed to inferential judgments. Arnhoff (1954) and Cronbach (1960) suggest that naive assessors are often more reliable in their judgments of psychopathology than expert clinicians, and are more likely to confine their judgments to the dimension at issue, rather than basing them on extraneious or tangential inferences.

Despite our consensual opinion that clinical experience is not necessary for valid Experiencing ratings, the question needs to be put to empirical test. The present study, therefore, considers the effects of level of judge clinical experience on EXP Scale ratings of tape-recorded sample of the therapy interaction. The expectation is that level of judge experience will have no effect on the reliability or validity of EXP ratings obtained--i.e. interrater reliabilities as well as average EXP characterizations of a sample of tape-recorded segments will be equivalent for groups of relatively experienced in contrast to clinically naive judges.

Method

Tape-Samples of Psychotherapy

A sample of 42 tape-segments were selected from a pool of tapes extracted from individua lpsychotherapy sessions available from two previous studies (Kiesler et al., 1964, 1965). These earlier studies analysed samples of early (within the first five) and late (within the last five) interviews from the psychotherapy sessions of 8 schizophrenic patients from a Wisconsin state hospital (Rogers et al., 1967), 8 psychoneurotic patients from the University of Chicago Counseling Center, and 8 normal subjects (members of church and farm organizations in Wisconsin) who participated in quasi-therapy sessions as part of the Wisconsin schizophrenia project (Rogers et al., 1967). These 24 cases had been randomly selected from larger pools of cases regardless of outcome or other considerations. The size of segment-samples available were of 2-, 4-, 8-, and 16-minute duration extracted randomly from particular 50-minute therapy interview.

Several restrictions were placed on the sampling from these available tape-segments for the present study. The sample of therapy segments chosen had to 1) represent adequately the range of the Experiencing Scale stages (7-points) as determined by available EXP ratings, 2) to sample equivalently as closely as possible the 3 patient diagnostic groups as well as the early and late therapy points, and 3) to sample equivalently segments of 2-, 4-, and 8-minutes duration.

As a result of this restricted sampling procedure, a sample of 42 tape-segments was selected, containing 12 segments of 2-minute lingth, 19 of 4-minute length, and 11 of 8-minute duration. These 42 samples had previously been rated by a group of undergraduate judges with the following breakdown regarding EXP Scale stages: 8 segments were at stage 1, 11 at state 2, 8 at stage 3, 8 at stage 4, and 7 at stage 5--ratings at stage 6 are relatively rare, and stage 7 ratings (the highest level of the scale) are almost nonexistant. All but 4 of the 42 segments came from the Kiesler et al., (1964) study, the remainder from Kiesler et al. (1965). Of the segments 15 were of schizophrenic patients, 14 of psychoneurotics, and 13 of normals. Thus, the 42 segments of the present study represent a cross-section of individual psychotherapy of schizophrenic, psychoneurotic and normal cases; with a relatively balanced representation of different segment-lengths (2-, 4-, and 8-minute), sampled from very early and very late in the therapy sequence; and depicting the most frequently occurring stages of the EXP Scale (stages 1-5).

Judge Groups

Two groups of judges were compared for the present study. The inexperienced judges were a group of 4 clinically naive undergraduates (2 males, 2 females), all liberal arts students at the University of Wisconsin who, at the beginning of their training, had no prior experience with the EXP Scale or with recorded therapy interactions. The 4 experienced judges were 3 clinical psychologists and 1 counseling psychologist on the faculty of the Department of Psychology at Emory University (2 males, 2 females). The range of their clinical experience was from 3 to 9 years post Ph.D.

Both groups of judges were trained using the Experiencing Scale Manual (Klein et al., 1969). The procedure involves listening to 90 training segments, 2 to 16 minutes in length, with the trainee subsequently comparing his independent EXP ratings with the manual's criterion ratings and respective rationales. After independent ratings of successive blocks of 10 training segments, the inexperienced judges discussed with each other the discrepancies in their ratings. The manual's criterion ratings set the standard in all cases, so that discussion was directed to clarification of the manual's viewpoint. The experienced judges, on the other hand, trained themselves individually with the Experiencing Scale manual, since for practical reasons they could not be trained together in a group. This was the only difference in the training procedure for the two groups of judges.

As part of their training all judges were instructed to make two separate ratings for each segment. The first, a modal rating, was their estimate of the EXP level of the segment as a whole--the most frequently occurring level of EXP observed. The second, a peak rating, was their estimate of the highest level of EXP attained by the patient, if only momentarily, during the particular segment.

Upon completion of the training sessions, all judges independently listened to and rated in a standard random order the 42 experimental segments of the present study. The means of 4 judges' EXP ratings for each of the 42 segments (42 means for 4 experienced judges, 42 means for 4 inexperienced judges) represent the EXP scores used in the subsequent analyses.

Results

The expectation of the study was that upon rating an identical sample of 42 tape-segments of psychotherapy a group of experienced judges would yield equivalent EXP ratings to those of a group of inexperienced judges. More specifically, interrater reliabilities for, and mean characterizations of, EXP ratings on the 42 segments would be equivalent for the two judge groups of 4 raters each.

Ebel intraclass reliabilities (Guilford, 1954) were calculated for each of the judge groups for the 42 EXP ratings. Ebel's procedure provides two reliability indices; r_{11} is an estimate of the average intercorrelation among each set of 4 judges, and r_{kk} represents the reliability of the mean EXP rating of the 4 judges. Table 1 presents the r_{11} and r_{kk} coefficients for the two sets of 4 judges, for both the

Table 1

Ebel Intraclass Reliabilities (r_{11} and r_{kk}) of the Modal and Peak Experiencing Ratings of Experienced vs Inexperienced Judges (k = 4 judges, n = 42 segments).

		Experienced Judges (k = 4)	Inexperienced Judges (k = 4)
r_{11}	Modal EXP	.707	.792
	Peak EXP	.733	.733
r_{kk}	Modal EXP	.906	.938
	Peak EXP	.916	.916

modal and peak EXP ratings. It's apparent from the Table that the interrater reliabilities of EXP ratings are virtually indistinguishable for the experienced and inexperienced judges, and are high in all cases (r_{11}s range from .71 to .79, r_{kk}s range from .91 to .94). Hence, both experienced and inexperienced raters achieve equally high interrater reliabilities when applying the Experiencing Scale to an identical sample of 42 tape-segments.

The mean EXP ratings of the 4 experienced judges were intercorrelated with the mean ratings of the 4 inexperienced judges for the 42 tape samples. The resulting Pearson coefficients were .89 for the modal ratings and .87 for the peaks (df = 42). This indicates that the ranking of the 42 segments in terms of EXP scores is virtually the same for both the experienced and inexperienced judges, with 78.5% of the variance of the two sets of scores in common for the modal ratings, 76.2% for the peaks.

Finally, the average EXP scores for the total 42 segments for the two judge groups were calculated and compared. The means and standard deviations of the modal and peak EXP ratings for the 42 patients, calculated for the experienced and inexperienced judges, are presented in Table 2. T-tests were calculated for the modal and peak EXP scores for the two groups. The resulting t values were 0.77 and 0.20 (df = 42) for the modes and peaks respectively, both statistically nonsignificant. The values indicate that the small differences in the average EXP ratings given to the 42 segments by the experienced and inexperienced judges were very likely the result of chance factors alone.

Discussion

The results provide unanimous support for the expectation that there would be no differences in reliability and validity of Experiencing Scale ratings made by experienced in contrast to inexperienced sets of judges rating the same tape-recorded samples of the psychotherapy interaction. The interrater reliabilities were indistinguishable and very high (.91 to .94) for the EXP ratings of the two groups. Ratings of the 42 segments by the two judge groups were positively correlated (.89 for modes, .87 for peaks) to a degree approaching the limits of reliability of the ratings. The means and standard deviations of the average EXP ratings for the 42 segments were indistinguishable for both judge groups, as evidenced by t-test. The upshot is that when groups of clinically experienced and naive judges rate the same tape-recorded

Table 2

Means and Standard Deviations of the Modal and Peak EXP Scores for 42 tape-recorded segments, for the Experienced vs Inexperienced Judge Groups

		Experienced Judges (k = 4)	Inexperienced Judges (k = 4)
Modal EXP:	Mean	2.65	2.72
	SD	1.03	1.22
Peak EXP:	Mean	3.24	3.22
	SD	1.09	1.23

samples of individual psychotherapy the resulting EXP ratings are equivalent in all respects. Hence clinical experience is irrelevant to the EXP rating task.

This is a highly encouraging finding. It implies that the efforts expended to anchor the EXP Scale with tape-recorded examples of the various scale stages, and to standardize a training procedure that involves approximately 10-16 hours spread out over time have yielded an assessment instrument that can be applied with good reliability and validity by judges of widely divergent experiential backgrounds. Importantly it shows that clinical experience is neither necessary for, nor detrimental to, learning and applying the EXP Scale. This in turn has considerable payoff vis a vis the economics of process research. Obviously it costs less to hire inexperienced judges in contrast to experienced ones. Further, if one has ongoing research where additional EXP ratings are required for successive studies, one can utilize again and again the same trained judges if they remain in the same geographical vicinity. All that would be required is a brief re-training period with the Manual, where the judges refresh their memory of the scale. Obviously this recurrent-use possibility can provide additional financial savings.

Finally, the findings suggest that the scale authors have indeed been able to keep the level of clinical or other inference required for valid Experiencing ratings at a minimum. If this were not the case the findings of the present study would have been dramatically different.

B. Patient Experiencing and Successful Outcome in Individual Psychotherapy of Schizophrenics and Psychoneurotics

Although the traditional "insight" and "relationship" psychotherapies (in contrast to "action" types, (London, 1964; Patterson, 1966) have emphasized the importance of in-therapy patient process changes, only recently have theorists or researchers begun to make explicit the quality of talking-about-oneself behavior that is theoretically desirable for a patient to exhibit in the interview sessions. The neoanalytic and Rogerian positions are actually closer than previously emphasized regarding this ideal patient behavior in psychotherapy, although neither has taken much pain to formulate the extra-therapy patient changes that are mediated by, and/or correlates of, this in-therapy change (Ford & Urban, 1964; Kiesler, 1966).

Rogers (1958, 1959; Rogers et al., 1967) was the first to spell out in some detail the patient process behavior indicative of changes in internal functioning that should characterize a successful therapeutic relationship. Although couched in phenomenonological language consistent with his basic theoretical stance, a close analysis of Rogers' description reveals many similarities to the neoanalytical (Fenichel, 1945; Sullivan, 1965; Fromm-Reichmann, 1950; Alexander & French, 1946; Singer, 1965) constructs of "insight," lack of "resistance," and "working through." The upshot is that the ideal in-therapy behavior desired of a psychotherapy patient seems to encompass his ability to focus on and express freely the feeling, attitudinal and meaning correlates of his behaviors and experiences; to compare, contrast and intergrate the affective and rational components of this complex; and to use this differentiated but integrated composite as an immediate referent for present and subsequent behavior, particularly in the interperaonal sphere. All of this, of course, implies growth and change.

"In this perspective the therapist's job is to help the patient expand his experiencing by supporting the process of focusing, and by guiding exploration and integration. In experiential terms a properly timed therapist intervention is one that moves just a step beyond the patient's experiential level and points toward the next-most-important implicit meaning or aspect of his experiencing." (Klein et al., 1969). In neoanalytic terms, similarly, the best therapist intervention is one that "interprets just beyond the preconscious" (Fenichel, 1945).

The Experiencing construct is a phenomenological statement of this ideal in-therapy patient behavior. Its operational statement, the Experiencing Scale (Klein et al., 1969) evolved from Rogers' original process conception (1958, 1959) Gendlin's theoretical refinement of the Experiencing component of Rogers' conception (Gendlin, 1962), and the earlier form of the scale (Gendlin & Tomlinson, 1961).

A detailed review of the literature involving the Experiencing Scale can be found in a chapter of the Experiencing Scale Manual (Klein et al., 1969) as well as in Rogers et al. (1967). Briefly, Rogers' original process conception (1958, 1959) detailed seven "strands" or aspects of process which change together in successful psychotherapy. These include the constructs of relationship to feelings and personal meanings, manner of experiencing, congruence, commitment of self, personal constructs, relationship to problems, and manner of relating. The correlated changes outlined for these dimensions basically specify the changes in internal functioning essential for personality change, and establish their sequence apart from the specific problems and content areas involved--in effect, define the optimally healthy person. "Although different patients may start psychotherapy at different points on the continuua, work over different ranges of the scale, work at different rates, or recycle through the various stages many times, perhaps taking up and resolving different problems and aspects of their lives, progressively more advanced levels of focusing are essential for progress in any area." (Klein et al., 1969).

Several studies based on this original conception (Walker, Rablen, & Rogers, 1960; Gendlin, Jenney, & Shlein, 1960; Tomlinson & Hart, 1962; Tomlinson, 1962, 1967; Stoler, 1963; and Van der Veen, 1965, 1967) generally provide support for the relationship of the original process variables to more successful outcome for schizophrenic and psychoneurotic patients, to physiological measures, and to client likeability.

Gendlin expanded the Experiencing construct and devised an experimental, instructional procedure to facilitate client "focusing," a construct very similar to Experiencing. His research program has concentrated to date on the psysiological and personality correlates of focusing ability, primarily among nonpsychiatric patients (Gendlin et al., 1968).

The Experiencing Scale used in the present study (Klein et al., 1969) is a modification of Gendlin & Tomlinson's (1961) original Experiencing Scale, which was designed to measure one of the seven strands of Rogers' process conception. The present scale has been standardized to the point that raters can train themselves, individually or in groups, to apply the scale in a reliable and valid manner. Ninety tape-recorded training samples, with annotated criterion ratings for each, are an integral part of the training procedure. The final version of the scale focuses, more than the earlier Gendlin & Tomlinson format, on the patient's manifest verbal behavior, in an attempt to minimize the inferences required of raters. It assumes that the patient's overt description of his Experiencing is a valid index of the quality of his internal Experiencing. The rating is basically content-free (i.e. independent of the particular topic or problem being discussed), focusing rather on the formal manner in which the patient is talking about himself.

Much effort has been expended to resolve some basic methodological issues, inherent in any process research (Bordin et al., 1954; Kiesler, 1966, 1970), for the Experiencing Scale. Various problems such as optimal size (i.e. tape segment size) of the EXP process unit (Kiesler et al., 1964), appropriate location of extracted samples within the individual recorded session (Kiesler et al., 1965), potential confounding of EXP ratings from the degree of patient verbal productivity (amount of time talk) in the particular tape segment (Kiesler et al., 1966), potential confounding of EXP due to the presence of therapist verbalizations on the tape samples (Schoeninger et al., 1967), the degree of clinical experience necessary for valid EXP ratings (Kiesler, 1969) have all been resolved for the EXP Scale. These findings indicate that valid ratings can be made by either clinically naive or sophisticated judges; that the size of segment samples can be either small or large (2-16 minutes) with no loss of reliability or validity so long as the size is standardized for a particular study; that significantly different trends of EXP are present within the individual therapy session for different diagnostic groups, and that one must be careful how he samples location-wise (early, middle or late in the hour) particularly if his number of samples is small; that EXP differentiations of diagnostic types and outcomes is unaffected if the amount of time the patient talks in the tape-segment is statistically controlled by covariance analysis; and that the presence or absence (therapist talk edited out) of the therapist's verbalizations on tape-segments has no effect on the reliability or validity of the EXP ratings obtained. Finally, the interrater reliability of judges' EXP ratings has been good (Ebel intraclass reliabilities range from .76 to .93 in previous studies) when at least three judges independently rate the experimental tape-segments in a standard random order, and the mean of the judges' ratings is used as the EXP score for a particular segment.

The 1969 version of the EXP Scale was applied in the Rogers et al. (1967) study of individual psychotherapy with hospitalized schizophrenic patients. In that study level of patients Experiencing was found to relate positively to more successful outcome (MMPI Sc, Hs, and Pd improvement; Q-sort adjustment change; clinical evaluations of test change; percent-time out of the hospital after therapy termination) and to rated and perceived (Barrett-Lennard's Relationship Inventory) high levels of Rogers' therapist "conditions.") There was a consistent tendency present for patients who showed deeper (higher) levels of Experiencing to be the ones whose therapists were high on Rogers' level of conditions (rated empathy and perceived congruence) and the ones who were designated successful outcomes by psychometric and hospital-discharge rate indices.

The interpretation of these findings, however, was clouded by the additional findings that level of Experiencing in therapy (as well as level of therapist conditions) is also related to a constellation of trait variables present in patients before therapy was initiated. That is, high in-therapy Experiencing patients were, before therapy, characterized as showing an initial absence of depression (Wittenborn ward behavior ratings), higher verbal facility (WAIS Verbal score), higher verbal productivity (silence index taken from first recorded interview) and verbal expressitivity (TAT productivity ratings), and were more likely to be of the same male sex as the majority of therapists of the study and from a higher socio-economic background than were schizophrenics showing lower levels of self-exploration in therapy.

These latter findings, as well as the fact that evidence for EXP change in therapy for the schizophrenics was unclear, highlight an important issue regarding the Experiencing construct. Do the scale ratings reflect a change or improvement dimension in therapy characterizing successful outcome (a state construct)? Or, in contrast, do they represent a trait dimension (a readiness, or relatively constant ability, to Experience) which remains relatively constant over therapy and which is related to more successful outcome? The evidence to date is equivocal. Some studies show evidence for the state or change construct (Tomlinson, 1962, 1967; Van der Veen, 1965, 1967; Kiesler et al., 1967; Ryan, 1966), while others show more evidence for the trait conception (Rogers et al., 1967; Tomlinson & Hart, 1962; Kiesler et al., 1964; Schoeninger, 1965). Generally, the evidence seems to suggest that the scale is sensitive to fluctuations from one interview to another and within a particular interview. But it remains a question whether an unfaltering progression in Experiencing is present over successful therapy, or whether psychotherapy is more often characterized by alternating periods of progress and backsliding. Further, since most previous studies of Experiencing (Rogers et al. (1967) excepted) have analysed only several individual session-points of the total psychotherapy sequence, it seems likely that only a more exhaustive and intensive analysis will shed clear light on the issue.

The present study, therefore, has several purposes. First, it takes a much more intensive look at in-therapy Experiencing by combining a relatively exhaustive sampling of a group of psychoneurotic patients in individual psychotherapy with the previously intensively sampled therapy sessions of hospitalized schizophrenic patients (available from the Rogers et al. (1967) study). As a consequence Experiencing ratings were obtained on samples from each of the first thirty tape-recorded sessions for the two groups of patients in individual psychotherapy. This sampling provides an exhaustive coverage of the earlier phases of individual psychotherapy with schizophrenic and psychoneurotic patients. Further, since it represents a period of approximately 8 months therapy duration, on the average it samples exhaustively the majority of psychotherapy as traditionally practiced (orthodox analysis excepted). Secondly, this detailed assessment should provide a much clearer look at the process of patient Experiencing in psychotherapy. It should thereby provide a clearer answer to the state vs trait issue regarding the Experiencing dimension. If reliable changes or improvement in Experiencing occur in therapy, this detailed sampling should reveal its presence. Finally, the present study attempts to relate Experiencing to independent measures of more successful outcome to attempt to substantiate further the positive relationships found in previous studies.

The present study, therefore, focuses on the process of patient Experiencing in psychotherapy during each of the first thirty interview sessions for a group of 14 hospitalized schizophrenics (Rogers et al., 1967) and a group of 26 psychoneurotic outpatients who participated in individual psychotherapy as part of a previous psychotherapy research project (Hunt et al., 1959).

The hypotheses assessed in the present study are the following. 1) Both more-successful schizophrenic and more-successful psychoneurotic patients (as defined by independent outcome criteria) will show a higher level of Experiencing during the first thirty therapy sessions than will their less-successful counterparts. 2) Both more-successful schizophrenic and more-successful psychoneurotic patients will show more positive change in Experiencing (i.e. move toward higher EXP scores) over the first thirty sessions than will their less-successful counterparts. 3) the amount of this positive change will be significantly greater for more-successful psychoneurotic patients than for the more-successful schizophrenic patients. Finally, 4) the level of Experiencing during the first thirty psychotherapy interviews will be significantly higher for the psychoneurotic in contrast to the schizophrenic patients, regardless of outcome.

Method

Subjects. Two populations were sampled for the present study. (a) Illinois Psychoneurotics: The first sample was drawn from a larger sample of University of Illinois Counseling Center clients who participated in a previous research project at that center (Hunt et al., 1957, 1958a, 1958b, 1959).[1] As part of their project, the Illinois researchers had tape-recorded every psychotherapy interview for their sample of psychoneurotic clients participating in the research project. As a result, tape recordings were available for much of the total therapy sequence for a group of 191 psychoneurotic clients who experienced psychotherapy with 13 different counselors.

The population for the original study was any person coming to the Illinois Counseling Center in search of psychological services. The population was further delimited to include only those applicants who reported personal and/or vocational problems, in contrast to those coming for educational advice only. Each person having a personal and/or vocational problem was included in the project if his problem was judged serious enough to require three or more interviews--i.e. "every person with a 'significant' problem was included.

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[1] The author expresses gratitude to Dr. Thomas N. Ewing of the Student Counseling Service at the University of Illinois for his gracious assistance throughout the present project, and particularly for making the original therapy tape-recordings available to the author so that samples from the originals could be extracted and transcribed.

A "significant Problem" was defined as a problem "involving motivational conflict or choice, or negatively, as calling for something more than giving information about the regulations of the college, or about vocational openings, for instance."

The final sample of 191 psychoneurotic clients ranged in age from 17 to 36 years, with by far the majority falling in the 17 to 26 range. Seventy-one percent were male, twenty-nine percent female. Seventy-six percent of the clients were judged as voluntary, twenty-four percent as referred. Of the clients eighty-one percent were single and nineteen percent were married.

For the present study a subsample was selected from the original Illinois project population. For purposes of comparability the Illinois clients were sampled who presented equivalent raw interview data to those of the patients in the Wisconsin schizophrenia study (Rogers et al., 1967) described below. As a result, only 26 of 191 Illinois clients for whom some recordings were available met the minimum requirement for inclusion in the present study--i.e. only 26 clients both had participated in at least the required 30 interview sessions, and also had the recordings available.

These 26 Illinois clients having tape recordings available for their first thirty psychotherapy interviews represent the sample of psychoneurotic patients for the present study. Table 3 presents a demographic comparison of these 26 patients with the original Illinois sample of 191 patients.

The 13 counselors who participated in the Illinois study represented a wide range of psychotherapy schools or viewpoints. At the beginning of the project 4 counselors were selected who represented four different schools: neofreudian, Adlerian, eclectic, and client-centered. These 4 counselors were instructed to adhere as closely as they could to their respective viewpoints. Later in the project 9 additional counselors were included for various reasons, and these counselors were not asked to try to represent any particular school. The counselors were assigned clients in accordance with a simple rotational scheme (first client to Counselor A, second to Counselor B, and so on).

The clients took part in pre-therapy diagnostic procedures, including a diagnostic interview as well as n extensive test battery. At the third interview both counselor and client filled out various rating forms on each other. After

Table 3

Comparison of the Percentage of Cases for the Original Illinois Client Population (n = 191) vs the Sample of Clients (n = 26) Drawn for the Present Study, on the Variables of (1) Number of Therapy Interviews, (2) Number of Months in Therapy, (3) Age, (4) Marital Status, and (5) Sex.

1) No. of Therapy Interviews:	Original Illinois Study (n = 132)	Present Study (n = 26)
1-10	42.4%	0.0%
11-20	20.4	0.0
21-30	15.3	23.1
31-40	10.0	38.5
41-50	6.1	11.5
51-60	.7	3.8
61-70	.7	3.8
71-80	1.5	7.7
81-90	0.0	0.0
91-100	1.5	7.7
101-110	0.0	0.0
111-120	.7	3.8
121-130	.7	0.0
	100.0%	100.0%

2) No. of Months in Therapy:	Original Illinois Study (n = 132)	Present Study (n = 26)
<1	8.4%	0.0%
1-3	29.8	0.0
3-5	17.5	0.0
5-7	13.7	7.7
7-9	10.7	34.7
9-11	1.5	7.7
11-13	3.8	15.4
13-15	6.1	15.4
15-17	1.5	0.0
17-19	3.8	7.7
19-21	.8	3.8
21-23	.8	3.8
23-25	0.0	0.0
25-27	.8	3.8
27-29	0.0	0.0
29-31	.8	0.0
	100.0%	100.0%

3) Age:	Original Illinois Study (n = 181)	Present Study (n = 26)
17-18	16.0%	7.7%
19-20	17.1	15.4
21-22	21.5	15.4
23-24	18.2	23.2
25-26	13.8	15.4
27-28	6.6	11.5
29-30	2.8	3.8
31-32	1.2	0.0
33-34	1.6	3.8
35-36	1.2	3.8
	100.0%	100.0%

4) Marital Status:	Original Illinois Study (n = 172)	Present Study (n = 26)
Single	81%	81%
Married	19	19
	100%	100%

5) Sex:	Original Illinois Study (n = 191)	Present Study (n = 26)
M	71%	77%
F	29	23
	100%	100%

6) Year in College:	Original Illinois Study (n = 185)	Present Study (n = 26)
Freshman	25.0%	15.4%
Sophomore	12.0	15.4
Junior	20.0	11.5
Senior	17.0	11.5
Graduate	19.0	34.7
Staff	5.0	7.7
Non-Student	1.0	0.0
Special Student	1.0	3.8
	100.0%	100.0%

termination, each client participated in a post-therapy diagnostic interview and again took an extensive test battery. The original test battery contained the MMPI, Cattell 16PF Test, McQuitty's Integration Tests, Osgood's Semantic Differential Test filled out on 16 different persons and concepts, the Ewing Rating Form (an adjective check list), the Rorschach, the TAT, the Gilbert Self-Interview (client talks about himself to a tape recorder), the Watson Projective Test, and the Davits Projective Test. For various reasons there is much missing data for these test measures, which makes it impossible to use them for pre-post change assessments of the 26 clients of this study. The only outcome data from the original project which is consistently available for the present 26 clients is the rating made by the therapist at the time of termination on the Hunt-Kogan Movement Scale (Hunt & Kogan, 1950). The Movement Scale was used by the project as the primary, global scale for judgment of improvement in adjustment as seen by the therapist. The original therapist judgments made on the scale for each client ranged from 0-40, but were collapsed later to a 9-point scale of improvement, with 9 representing most improvement in adjustment.

The 26 clients of the present study were divided into "more successful" (MS) and "less successful (LS) groups by means of their Hunt-Kogan scores. A clearcut dichotomization resulted with 13 MS and 13 LS psychoneurotic patients. The MS Ss' Movement scores ranged from 5-8 with a mean of 5.85, whild the LS Ss' Movement scores ranged from 1-4 with a mean of 3.38.

One would desire more objective change assessment data with which to analyse psychotherapy process data, for clearly the possibilities of multiple and complex biasing exist in these judgments of change in adjustment made by the counselors who performed therapy with the respective clients. Nevertheless it is the best data available for the present Ss. Theoretically, a relationship should be expected between this outcome dimension and the level of patient Experiencing occurring in the interviews. Whether this relationship, if present, can be extrapolated to more objective measures of extra-therapy change cannot be assessed by the data of the present study.

(b) Wisconsin Schizophrenics. The second sample for this study was drawn from a population of hospitalized schizophrenic patients from Mendota State Hospital in Madison, Wisconsin. The 14 schizophrenic patients of the sample represent the entire sample of experimental patients in the Wisconsin schizophrenia project (Rogers et al., 1967). As part of the Wisconsin project every individual psychotherapy interview was tape-recorded. As a result tape recordings were available for the total therapy sequence for the 14 hospitalized schizophrenic patients seen in individual psychotherapy by 8 different therapists. The 8 therapists who volunterred to participate in the study, while varying somewhat in their orientation and technique, generally clustered toward a client-centered point of view in therapy. There was a mixture of relatively experienced and inexperienced therapists.

All 14 patients were diagnosed "schizophrenic" by the staff of Mendota State Hospital. Excluded from the population of diagnosed schizophrenics were any patients with concurrent conditions of organic central nervous system damage, mental deficiency, narcotic addiction, or major physical disability, as well as any patients with a record of psychosurgery. Likewise, any patients having had a course of more than 50 EST or IST were eliminated.

The 14 cases selected were divided equally between males and females. They ranged in age from 28 to 44, with a median age of 35. Half the cases were chronic and half acute. The "more chronic" patient was defined as one who had been hospitalized with a diagnosis of schizophrenia for a total of more than 8 months in his lifetime. The "more Acute" patient was defined as one who had been hospitalized with a diagnosis of schizophrenia for a total of less than 8 months in his lifetime. In respect to the process-reactive continuum (Herron, 1962) the 14 Ss fell in the middle range of the Phillips Premorbid Scale--hence were not pure cases of either process or reactive schizophrenia.

By agreement with the hospital staff the 14 therapy patients were not to receive any ataractic medication during the time of therapy, except in emergency situations when the ward physician might find such medication necessary to control violent or difficult behavior. Despite this, however, tranquilizers were administered to some of the therapy patients. For some patients this was an occasional thing; for others drugs were sometimes felt to be necessary over fairly long periods. Generally, there was some contamination of the study by the concurrent administration of drugs.

Various outcome measures were used to assess constructive personality change from pre to post therapy and at follow-up periods. These included the MMPI, Q-Sort, overall assessments of change by the therapist, Wittenborn Psychiatric

Rating Scales, TAT adjustment scores, and hospital discharge rates. For the present study the schizophrenic patients were dichotomized into "more successful (MS)" and "less successful (LS)" groups by means of two primary indices: 1) their MMPI Sc (schizophrenia) scale change scores from pre to post therapy, and 2) an overall assessment of pre to post change made by two experienced clinicians who did not participate in the project in any other way, and who made their assessments after close examination of the entire pre and post psychomentric data available for each patient. These ratings of change will hereafter be referred to as the L-R ratings.[2]

Using the MMPI Sc change scores and the L-R ratings as a combined index, the schizophrenic sample was divided into 6 clearcut MS Ss, 6 clearcut LS Ss, with 2 patients of somewhat unclear status. These latter two fell at the lower end of the MS cases, but because of their ambiguous status, and in order to have equal ns in the cells for later statistical analyses, they were dropped from the study.[3] The MMPI Sc T-score changes ranged from -8 to -30 with a mean of -19.2 for the 6 MS Ss, and ranged from +3 to +10 with a mean of +5.2 for the LS Ss. The L-R overall ratings of improvement ranged from 4.0 to 7.5 with a mean of 6.0 for the MS cases, and ranged from 3.0 to 5.0 with a mean of 4.2 for the LS Ss. These dichotomizations are relatively clearcut, with no overlap at all between the groups for the MMPI Sc data. Generally, the 6 MS Ss showed reduction in schizophrenic pathology and were rated as more improved pre to post therapy, while the 6 LS Ss showed an increase in MMPI schizophrenic pathology and were rated as less improved pre to post therapy.

The MMPI Sc change scores and the L-R ratings were used for the present study since they provided the most clearcut and consistent differentiations of the schizophrenic therapy patients. Further, in the original project (Rogers et al., 1967) the MMPI Sc scores showed the clearest relationship with the Experiencing ratings of the therapeutic interviews. Finally, the L-R ratings are somewhat comparable to the Hunt-Kogan ratings used in the Illinois study, and thus permit relatively comparable MS-LS dichotomizations for the two samples.

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[2] L and R are the initials of the last names of the respective clinicians, Drs. John V. Liccione and Marshall B. Rosenberg.

[3] The author subsequently reanalysed the EXP scores reported in the results section, this time including these two dropped patients. Their EXP score also fell borderline between the original MS and LS groups. The statistical significance of the reported results was not changed by their inclusion.

Table 4 compares the 26 Illinois psychoneurotic patients with the 14 Wisconsin schizophrenic patients on demographic and other factors. Generally, although the nosological groupsings of the two samples are relatively gross, they nevertheless seem reliable and meaningful, representing significantly different psychiatrically disturbed populations. A reality difference between them--one group requiring hospitalization, and the other not--is sharp and clear. Further, the pervasive heterogeneity typically found in the loosely defined diagnosis of schizophrenia does not seem to be a problem for our present schizophrenic sample. The Wisconsin Ss are relatively well-defined operationally--diagnosed schizophrenics representing a moderately chronic group of hospitalized patients, falling near the middle of the process-reactive dimension. Finally, it is unlikely that the Illinois psychoneurotic sample includes any more seriously disturbed patients, since the MMPI profiles for the present 26 patients were checked to eliminate the presence of any more seriously disturbed ambulatory schizophrenics from that sample.

Procedure. Each of the tape-recorded sessions for the first thirty therapy sessions of the 12 Wisconsin patients and the 26 Illinois clients represent the original raw data of the study. Four-minute samples were extracted from each of these 38 x 30 or 1140 individual psychotherapy hours, and the 4-minute segments were rated by judges for level of Experiencing using the EXP Scale (Klein, Mathieu, & Kiesler, 1969).

The 12 x 30 or 360 4 minute segments and their corresponding EXP ratings for the schizophrenic patients were available from the Wisconsin project. Each of the 4-minute segments had been extracted randomly from the latter half of each of the 360 therapy hours. The segmenter entered the latter half of each tape at a randomly (table of random numbers) determined time-point, and a segment consisting of the four subsequent minutes was transcribed onto a 3-inch tape spool. There was one prerequisite--the segment taken had to contain a minimum of two patient statements and two therapist responses. If this criterion was not met by the

Table 4

Comparison of the Frequencies and Percentages of Cases in the Wisconsin Sample of 14 Schizophrenics (Scs) vs the Illinois Sample of 26 Psychoneurotics (Pts), for the Variables of (1) Number of Therapy Interviews, (2) Age, and (3) Sex.

(1) Number of Therapy Interviews:	Wisconsin Scs. (n = 14)		Illinois Pts. (n = 26)	
	%	frequency	%	frequency
<30	7.1	1	15.4	4
30-50	57.2	8	57.7	15
51-70	0.0	0	7.7	2
71-90	0.0	0	7.7	2
91-110	7.1	1	7.7	2
111-130	14.4	2	3.8	1
131-150	7.1	1	0.0	0
>150	7.1	1	0.0	0
	100.0%	14	100.0%	26

(2) Age:	Wisconsin Scs. (n = 14)		Illinois Pts. (n = 26)	
	%	frequency	%	frequency
17-20	14.35	2	23.1	6
21-24	7.1	1	38.5	10
25-28	14.35	2	26.9	7
29-32	14.35	2	3.8	1
33-36	14.35	2	7.7	2
37-40	0.0	0	0.0	0
41-44	21.4	3	0.0	0
45-48	14.35	2	0.0	0
	100.00%	14	100.0%	26

(3) Sex:	Wisconsin Scs. (n = 14)		Illinois Pts. (n = 26)	
	%	frequency	%	frequency
M	42.8	6	76.9	20
F	57.2	8	23.1	6
	100.0%	14	100.0%	26

first entry, the segmenter used his best judgment to find a segment meeting the criterion, first in another portion of the latter half of the therapy hour, or in the first half of the hour. This segmenting procedure yielded 360 4-minute segments, exhausting each of the first thirty therapy interviews for the 12 Wisconsin schizophrenic patients.

Tape-recorded segments for the 26 Illinois psychoneurotic patients were not available from that project, but were obtained for the present study. Although an attempt was made to obtain the segments in a manner comparable to the Wisconsin study, some modification was made. The segmenter extracted 4-minute segments from each recorded therapy hour--identical in length to the 4-minute Wisconsin segments. A previous study had demonstrated the necessity for controlling segment length in a particular study since longer segments tend to receive higher EXP ratings (Kiesler, Mathieu, & Klein, 1964). However, modification occurred in that the segmenter entered each individual session tape randomly (by table of random numbers) at any point of the therapy hour and recorded the four subsequent minutes of interaction. His segmenting was not restricted to the last half of the individual hour as was the intent for the Wisconsin segments.[4] One prerequisite was set, that at least one intervening therapist response had to be present in the 4-minute sample. If not, the segmenter entered again randomly until the prerequisite was met. As a result of this segmenting procedure 26 x 30 or 780 4-minute segments were available for each of the first thirty psychotherapy interviews for the sample of 26 psychoneurotic patients.

Experiencing Ratings. The purpose of the previous sampling was to provide tape-recorded segments from which judges could rate the patient's level of Experiencing. For

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[4] It is impossible to know the exact location of the segments extracted for the Wisconsin study since the segmenter kept no records of the time-points for his samples. However, a previous study (Kiesler, Klein, & Mathieu, 1965) indicates that since schizophrenics' EXP behavior during the individual therapy session shows a sawtooth pattern, exact location is not too crucial. The same study, on the other hand, showed a monotonic curve of EXP early to late in the hour for psychoneurotic Ss. If the latter half of the hour were sampled for the neurotics (as for the schizophrenics) there would be a bias present toward more productive moments for the neurotics. To eliminate this bias possibility, it was decided to sample the neurotics' sessions randomly.

the later analyses the primary dependent variable measure are the EXP Scale ratings made on each of the 360 schizophrenic and 780 psychoneurotic 4-minute segments.

The EXP ratings for the schizophrenic patients were available from the Wisconsin study (Rogers et al., 1967). Four clinically naive undergraduate student judges independently audited and rated the 360 segments in a standard random order. Each judge made two EXP ratings for each segment: a "modal" rating describing the overall, most frequent or average level of EXP in a particular segment, and a "peak" rating describing the highest momentary level of EXP attained at any point, however briefly, in the same segment. Since previous studies demonstrate that the mode and peak ratings correlate very highly (.80 to .90), only the modal EXP ratings will be reported in this study. The raters had no information concerning the nature of the case rated, the location of a given interview in the overall course of therapy, or the outcome of the case. The only information available was that contained in the coded taped segments drawn from the therapy interviews.

The 4 judges were trained in a larger group utilizing the standardized training procedure outlined in the Experiencing Scale Manual (Klein et al., 1969). The procedure involves listening to 90 training segments, 2 to 16 minutes in length, and subsequently comparing the trainee's ratings with the manual's criterion ratings. The manual's criterion ratings set the standard in all cases, so that discussion was directed to clarification of the manual's viewpoint.

Upon completion of the training sessions, the 4 judges independently listened to and rated the 360 experimental segments, on 3-inch spools in boxes of 12. Ebel intraclass reliabilities (Guilford, 1954) for the 4 judges for the 360 segments were acceptable--the reliability of the means of the 4 judges' EXP modal ratings was .76. In all subsequent EXP analyses the EXP score used is the mean of the 4 judges' EXP modal ratings for each segment.

The EXP ratings for the psychoneurotic patients were not available from the Illinois study, and were obtained for the present study. Four clinically naive, paid undergraduate student judges independently audited and rated the 780 psychoneurotic segments in a standard random order. The training and rating procedures were identical to those used in the Wisconsin study, as described above. Ebel intraclass reliabilities (Guildord, 1954) for the 4 judges for the 780 segments were acceptable--the reliability of the means of the 4 judges' EXP modal ratings was .79.

In summary, each of the 12 schizophrenic Ss and 26 psychoneurotic Ss obtained modal EXP ratings for a 4-minute sample randomly extracted from each of his first thirty psychotherapy sessions. The means of 4 judges' EXP modal ratings for the 360 schizophrenic and 780 psychoneurotic 4-minute segments (a total of 1140 4-minute segments) represent the primary dependent variable scores used in the later analyses. The EXP ratings provide an intimate analysis of the level and trend of patient Experiencing over the first thirty therapy interviews, a period reoughly equivalent to about 8 months.

Results

Three sets of analyses of the EXP ratings of the schizophrenic and psychoneurotic therapy interviews are presented below, covering respectively: a) the first twenty psychotherapy interviews, b) the first thirty therapy sessions, and finally c) the first five individual psychotherapy interviews. In all analyses the EXP scores used are the modal ratings, and constitute the mean of 4 judges' ratings for each particular 4-minute segment.

Patient Experiencing During the First Twenty Psychotherapy Sessions

The EXP scores of the 12 schizophrenic and 26 psychoneurotic patients were analysed for the first twenty therapy sessions. For each patient four EXP scores were calculated for his twenty 4-minute segments, representing the means of his four successive blocks-of-five interviews. That is EXP$_{1-5}$ (EXP$_1$ + EXP$_2$ + EXP$_3$ + EXP$_4$ + EXP$_5$ /5), EXP$_{6-10}$, EXP$_{11-15}$, EXP$_{16-20}$ were calculated for each S.

A 2 x 2 x 4 mixed analysis of variance (Edwards, 1962) for the 12 schizophrenic vs 26 psychoneurotic by more-successful (MS) vs less-successful (LS) outcome, by 4 interview time points ($\overline{X}_{1-5}$, $\overline{X}_{6-10}$, $\overline{X}_{11-15}$, $\overline{X}_{16-20}$) was calculated for the EXP scores. Table 5 presents the ANOVA summary table for this analysis. It's apparent from the table that all three main effects are statistically significant. The schizophrenic vs neurotic patient main effect is highly significant ($p<.01$), and indicates that the psychoneurotics as a whole, at all time points during the first twenty interviews, received higher (mean = 2.44) EXP scores than do schizophrenics (mean = 1.77). Psychoneurotics as

Table 5

Summary Table of the 2 x 2 x 4 Mixed Analysis of Variance of the EXP Scale Scores for 26 Psychoneurotic (Pt) vs 12 Schizophrenic (Sc) Patients, by More-Successful (MS) vs Less-Successful (LS) Outcome, by the 4 Interview blocks ($\overline{X}_{1-5}$, $\overline{X}_{6-10}$, $\overline{X}_{11-15}$, $\overline{X}_{16-20}$) over the First twenty Psychotherapy Interviews

Source of Variation:	Sums of Squares	df	Mean Squares	F Ratic	P
Sc vs Pt	14.94	1	14.94	30.12	.01
MS vs LS	3.03	1	3.08	6.21	.05
Sc-Pt x MS-LS	1.16	1	1.16	2.34	
Error (a)	16.87	34	.496		
Sessions	1.01	3	.337	3.66	.05
Sc-Pt x Sessions	.09	3	.030	<1	
MS-LS x Sessions	.02	3	.007	<1	
Sc-Pt x MS-LS x Sessions	.26	3	.087	<1	
Error (b)	9.39	102	.092	<1	
Total	46.82	151			

expected show a deeper level of self-exploration in their therapy interviews than do schizophrenic patients.

The MS-LS main effect is also statistically significant ($p<.05$), showing that more-successful patients, whether psychoneurotic or schizophrenic, attain higher (mean = 2.37) EXP scores than less-successful cases (mean = 2.09) at all points across the first twenty therapy sessions. The interaction between patient type and MS-LS is not statistically significant, indicating that the differentiation of more vs less successful cases is not different for the schizophrenic in contrast to psychoneurotic Ss.

Figure 1 presents the trends of EXP scores over the first twenty interviews for the schizophrenics vs neurotics and for the MS vs Ls comparisons. The two significant main effects just described are evident in the figure. Psychoneurotics attain higher EXP scores than schizophrenics at all 4 points of the first twenty interviews, and MS patients (regardless of diagnostic group) attain higher EXP scores at all points than do the LS Ss. In other words, regardless of where one samples over the first twenty interviews, a significant relationship is present between level of EXP and patient groups as well as outcome. The level of EXP is higher for psychoneurotics in contrast to schizophrenics, and for patients of more-successful outcome than for LS Ss.

In Table 5 none of the interaction effects with sessions as a component is statistically significant. This suggests clearly that the trends or slopes of EXP over the first twenty sessions for the four groups of patients are basically indistinguishable. However, the main effect for Sessions is statistically significant ($p<.05$) revealing that the EXP scores for all the patients, regardless of patient type or MS-LS designations, are different at the 4 5-interview blocks for the first twenty therapy sessions.

Figure 2 presents the trends of EXP scores for the four patient groups, as well as the mean scores at the 4 time points for all 4 groups combined (Sessions main effect). The overall trend shows a consistent drop in EXP level from the beginning of therapy through the 15th interview, then a rise in EXP through the 20th interview. The only group deviating at all from the overall trend is the MS schisophrenics, who show the initial drop but only through the 10th interview, and a consistent rise thereafter. However, this MS schizophrenic trend difference is not statistically significant.

Figure 1

Trends for EXP Scale Ratings for the Total More Successful (MS) vs Less Successful (LS) Groups (combining Pts and Scs), and for the Total Pt vs Sc Groups (combining MS and LS Ss), over the first twenty psychotherapy interviews. (n = 6 + 6 = 19 each for MS and LS Groups; n = 13 + 13 = 26 for Pts, n = 6 + 6 = 12 for Scs).

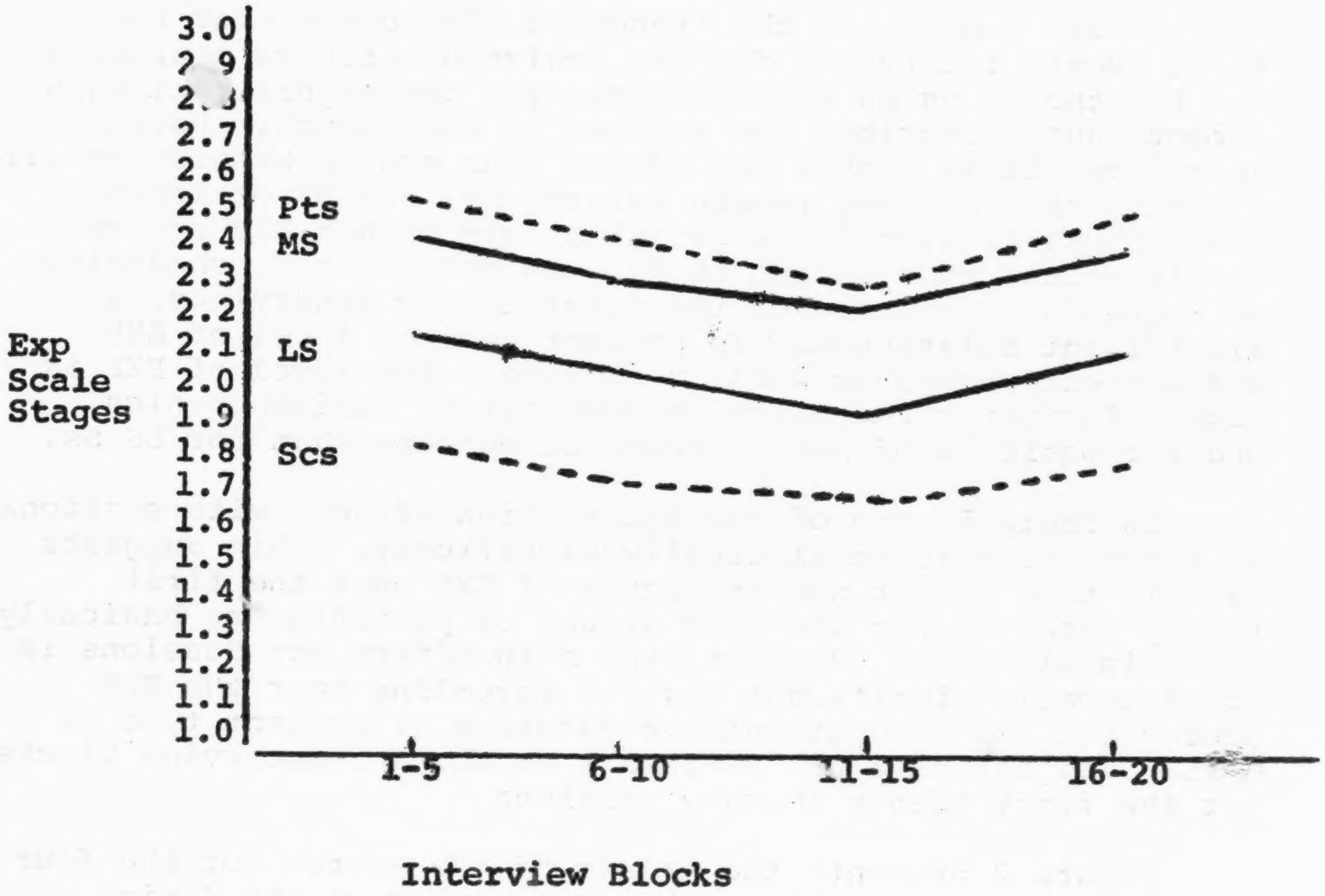
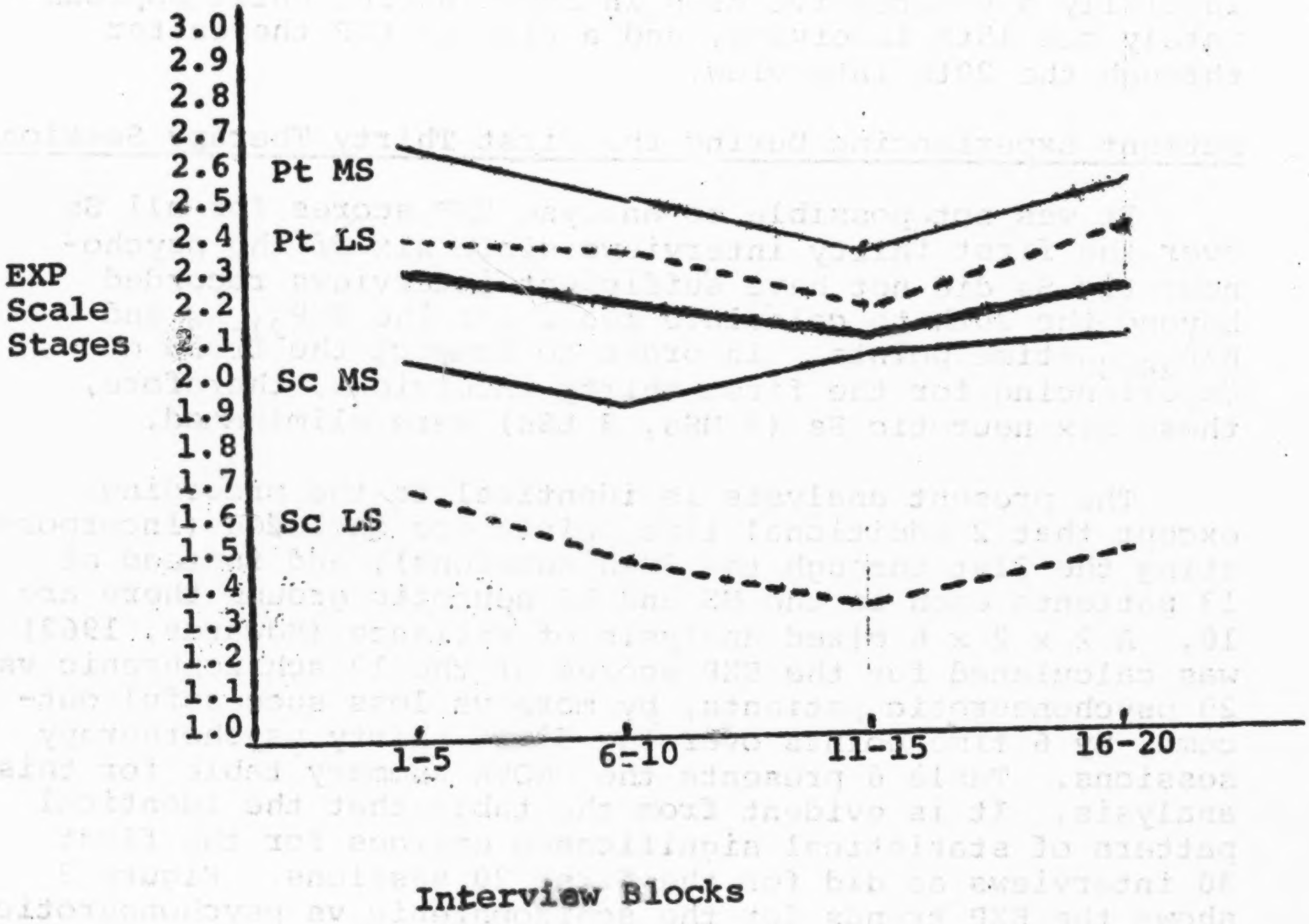


Figure 2

Trends of EXP Scale Ratings for the More Successful and Less Successful Psychoneurotic (Pt) vs Schizophrenic (Sc) Patients over the first twenty psychotherapy Interviews (n = 6 + 6 for Scs; n = 13 + 13 for Pts--total N = 38)



A trend-component analysis of variance was calculated for the scores to determine the shape of the EXP slope for the Sessions main effect. The trend analysis indicated the quadratic (U-shaped) component was statistically significant ($p<.01$), while the linear and cubic components were insignificant. Thus, the slope found for the EXP scores of all four patient groups is significant and takes a U-shaped form. All patients in individual psychotherapy (within the boundary conditions of the present study), whether schizophrenic or neurotic, more or less successful in outcome, show initially a progressive drop in Experiencing until approximately the 15th interview, and a rise in EXP thereafter through the 20th interview.

Patient Experiencing During the First Thirty Therapy Sessions

It was not possible to analyse EXP scores for all Ss over the first thirty interviews since six of the psychoneurotic Ss did not have sufficient interviews recorded beyond the 20th to calculate means for the EXP_{21-25} and EXP_{26-30} time points. In order to inspect the trend of Experiencing for the first thirty interviews, therefore, these six neurotic Ss (3 MSs, 3 LSs) were eliminated.

The present analysis is identical to the preceding, except that 2 additional time points are included (incorporating the 21st through the 30th sessions), and instead of 13 patients each in the MS and LS neurotic groups there are 10. A 2 x 2 x 6 mixed analysis of variance (Edwards, 1962) was calculated for the EXP scores of the 12 schizophrenic vs 20 psychoneurotic patients, by more vs less successful outcome, by 6 time points over the first thirty psychotherapy sessions. Table 6 presents the ANOVA summary table for this analysis. It is evident from the table that the identical pattern of statistical significance emerges for the first 30 interviews as did for the first 20 sessions. Figure 3 shows the EXP trends for the schizophrenic vs psychoneurotic and MS vs LS outcome main effect differentiations. Again there is no overlap of EXP scores between the two patient groups as a whole, with the psychoneurotics showing a significantly ($p<.01$) higher level of EXP (mean = 2.48) at all points of the first 30 interviews than do schizophrenics (mean = 1.79). Similarly, there is no overlap between more vs less successful outcome groups, regardless of diagnostic group, with MS schizophrenics and neurotics showing a higher level of EXP (mean = 2.35) than their less successful counterparts (mean = 2.09).

Figure 4 presents the EXP trends for the 4 patient groups over the first 30 therapy sessions. Once again there

Table 6

Summary Table of the 2 x 2 x 6 Mixed Analysis of Variance of the EXP Scale Scores for 20 Psychoneurotic (Pt) vs 12 Schizophrenic (Sc) Patients, by More-Successful (MS) vs Less-Successful (LS) Outcome, by 6 Interview-Blocks ($\overline{X}_{1-5}$, $\overline{X}_{6-10}$, $\overline{X}_{11-15}$, $\overline{X}_{16-20}$, $\overline{X}_{21-25}$, $\overline{X}_{26-30}$) over the First Thirty Psychotherapy Interviews.

Source of Variation:	Sum of Squares	df	Mean Square	F Ratio	P
Sc vs Pt	21.30	1	21.30	30.69	.01
MS vs LS	3.20	1	3.20	4.61	.05
Sc-Pt vs MS-LS	1.97	1	1.97	2.84	
Error (a)	19.42	28	.694		
Sessions	1.05	5	.210	2.24	.05
Sc-Pt x Sessions	.45	5	.090	<1	
MS-LS x Sessions	.16	5	.032	<1	
Sc-Pt x Ms-Ls x Sessions	.36	5	.360	<1	
Error (b)	13.24	140	.094	<1	
Total	61.13	191			

Figure 3

Trends for EXP Scale Ratings for the Total More Successful vs Less Successful Groups (combining Pts and Scs), and for the Total Pt vs Sc Groups (combining MS and LS), over the first thirty psychotherapy Interviews. (n = 6 + 10 = 16 each for MS and LS Groups, n = 10 + 10 = 20 for Pts, n = 6 + 6 = 12 for Scs).

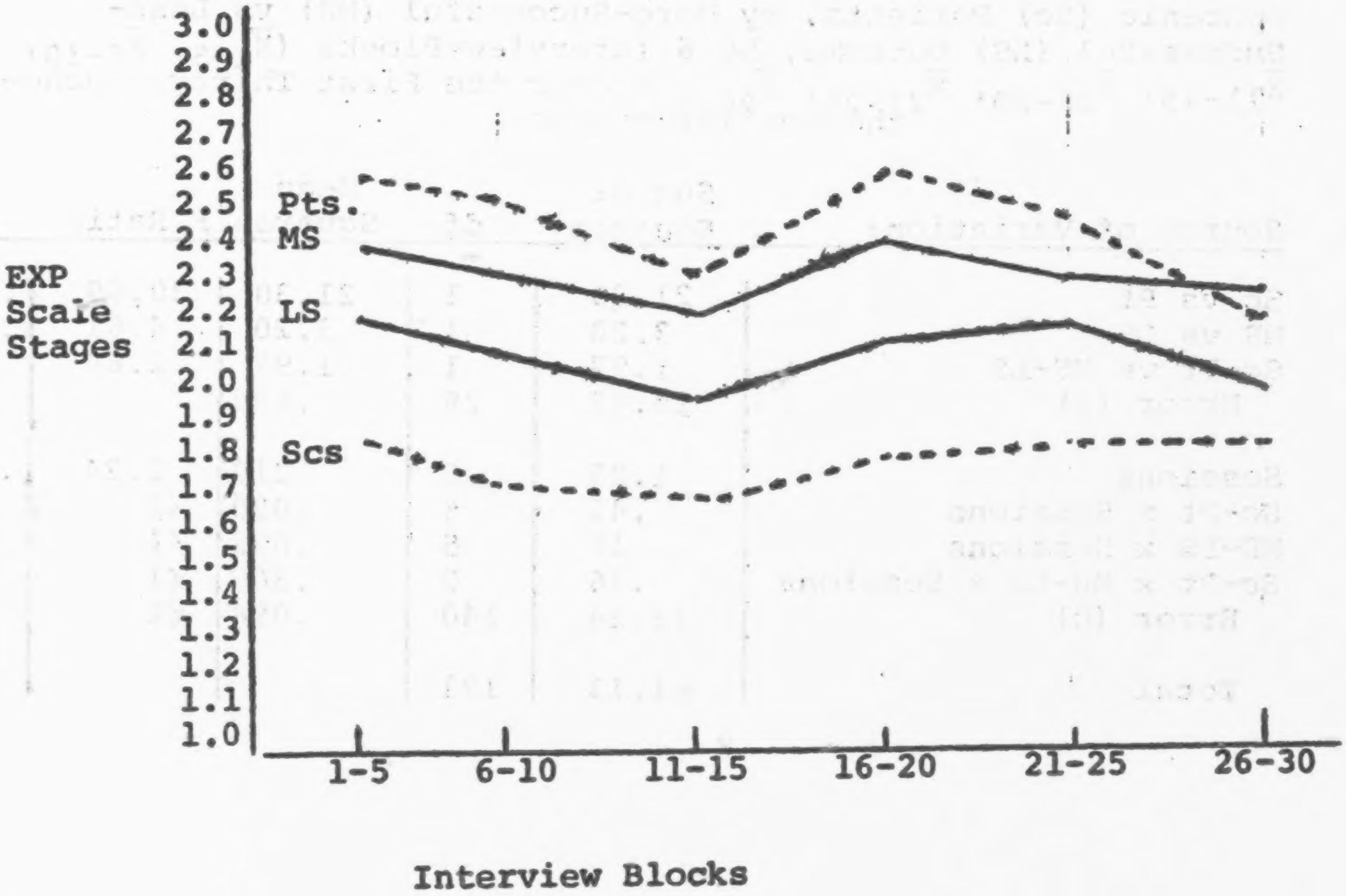
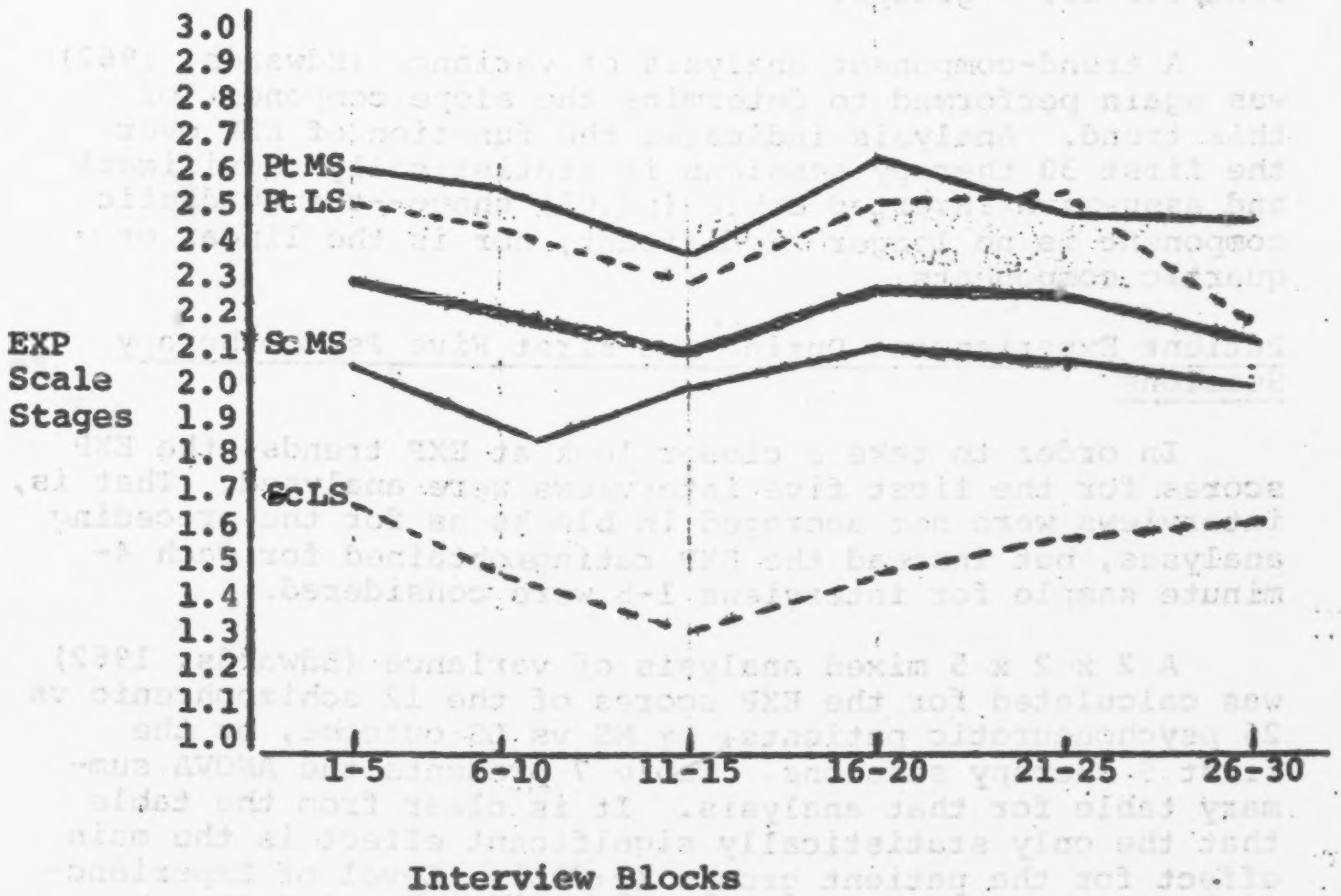


Figure 4

Trends of EXP Scale Ratings for the More Successful vs Less Successful Psychoneurotic (Pt) vs Schizophrenic (Sc) Patients, over the first thirty psychotherapy Interviews (n = 6 + 6 for Scs; n = 10 + 10 for Pts--total N = 32)



is no overlap at any of the time points among the means of the 4 groups, with one exception. The LS neurotics attain slightly higher EXP scores for the 21st-25th psychotherapy sessions than do the MS neurotics, but fall back below at the final interviews block. The U-shaped function for the 4 groups is again apparent through the 20th interview, but the rise which begins at the 15th interview does not continue consistently beyond the 20th interview. Since none of the interaction effects with Sessions as a component is statistically significant, the significant Sessions main effect ($p<.05$) depicted in the figure (combining all 4 groups at each time point) is the best estimate of the trend present for all 4 groups.

A trend-component analysis of variance (Edwards, 1962) was again performed to determine the slope component of this trend. Analysis indicated the function of EXP over the first 30 therapy sessions is statistically significant and assumes an inverted cubic ($p<.05$) shape--the quadratic component is no longer significant, nor is the linear or quartic components.

Patient Experiencing During the First Five Psychotherapy Sessions

In order to take a closer look at EXP trends, the EXP scores for the first five interviews were analysed. That is, interviews were not averaged in blocks as for the preceding analyses, but instead the EXP ratings obtained for each 4-minute sample for interviews 1-5 were considered.

A 2 x 2 x 5 mixed analysis of variance (Edwards, 1962) was calculated for the EXP scores of the 12 schizophrenic vs 26 psychoneurotic patients, by MS vs LS outcome, by the first 5 therapy sessions. Table 7 presents the ANOVA summary table for that analysis. It is clear from the table that the only statistically significant effect is the main effect for the patient groups ($p<.01$). Level of Experiencing is higher for psychoneurotic cases (mean = 2.57) than for schizophrenic cases (mean = 1.83) at each of the first five interviews. However, none of the other significant effects found in the previous first twenty and first thirty interviews analyses are significant here. That is, looking at the first five interviews only, neither the MS vs LS cases as a whole, nor MS vs LS Ss for a particular patient group alone, attain significantly different levels of Experiencing.

Examination of Figure 5 shows, however, that the non-significant trends are similar to those of the previous

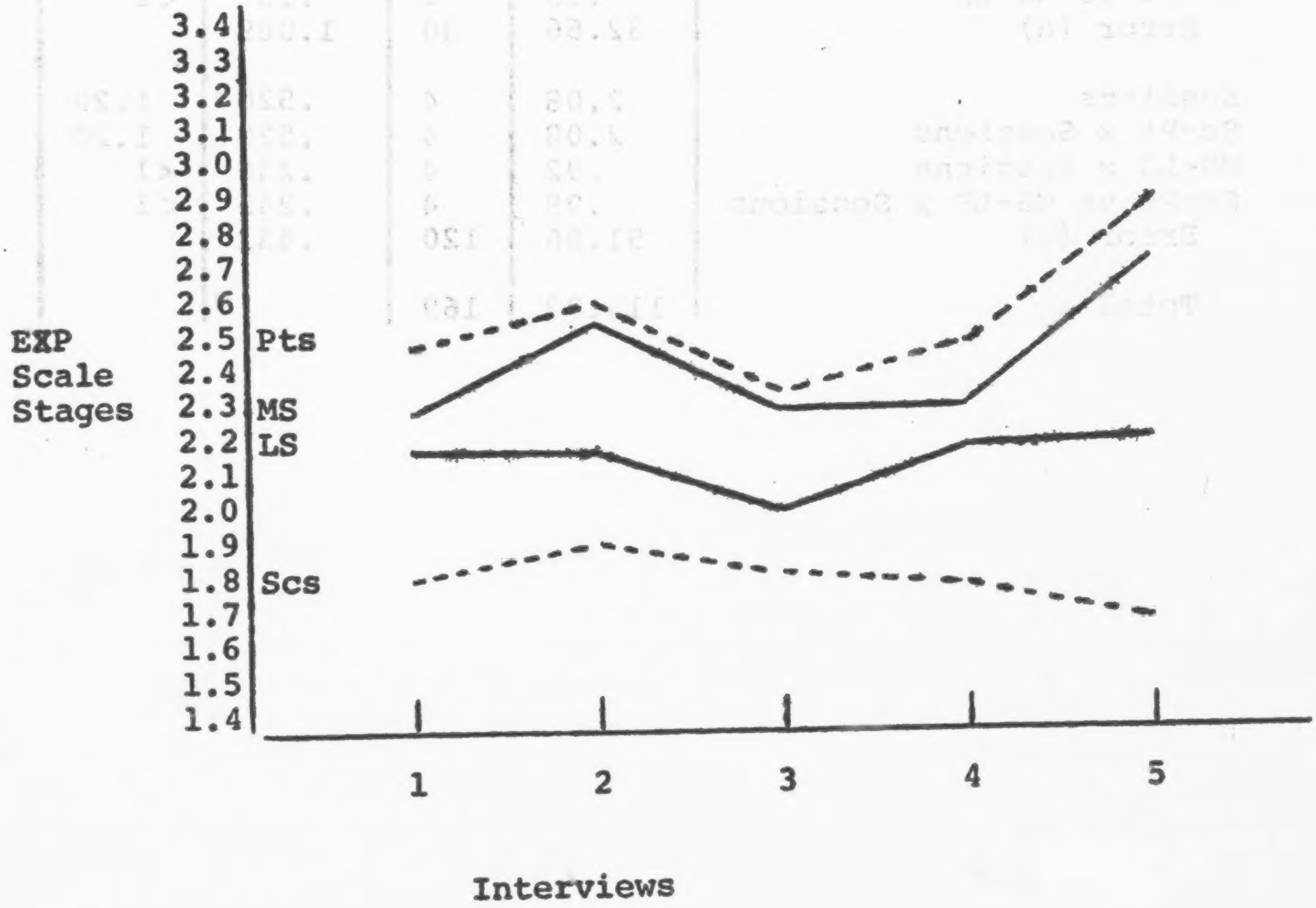
Table 7

Summary of 2 x 2 x 5 Mixed Analysis of Variance of the EXP Scale Scores for 22 Psychoneurotic (Pt) vs 12 Schizophrenic (Sc) Patients, by More-Successful (MS) vs Less-Successful (LS) Outcome, by the First 5 (1-5) Psychotherapy Interviews.

Source of Variation:	Sum of Squares:	df	Mean Square	F Ratio	P
Sc vs Pt	21.14	1	21.14	19.41	.01
MS vs LS	3.06	1	3.06	2.81	
Sc-Pt vs MS-LS	.15	1	.15	<1	
Error (a)	32.66	30	1.089		
Sessions	2.08	4	.520	1.20	
Sc-Pt x Sessions	2.08	4	.520	1.20	
MS-LS x Sessions	.92	4	.230	<1	
Sc-Pt vs MS-LS x Sessions	.98	4	.245	<1	
Error (b)	51.86	120	.432		
Total	114.93	169			

Figure 5

Trends of EXP Scale Ratings for the Total More Successful (MS) vs Less Successful (LS) Groups (combining Pts and Scs), and for the Total Pt vs Sc Groups (combining MS and LS), over the first five Psychotherapy Interviews. (n = 6 + 11 = 17 each for MS and LS Groups; n = 11 + 11 = 22 for Pt, 6 + 6 = 12 for Scs).



analyses (Figures 1 and 3). That is, there is no overlap at any of the time points between the mean EXP scores of the MS vs LS cases (psychoneurotics and schizophrenics combined), with the MS Ss receiving higher EXP scores.

Figure 6 presents the trends of the EXP scores for the 4 patient groups over the first five interviews, for comparison with previous figures. Although not statistically significant, the patterns found are similar to those in Figures 2 and 4. That is, both psychoneurotic and schizophrenic MS Ss obtain higher EXP scores than their respective LS counterparts.

From Figure 6 it is also apparent that the slopes of EXP over the first five interviews take clearly divergent shapes, in contrast to the parallel slopes found in Figures 2 and 4. Generally, instead of a gradual and progressive decline with subsequent rise in EXP found for the total thirty interviews, there seem rather to be alternating rises and falls in EXP level over the first 5 interviews for all 4 groups. That is, level of Experiencing vacillates rather markedly from interview to interview, at least very early in psychotherapy.

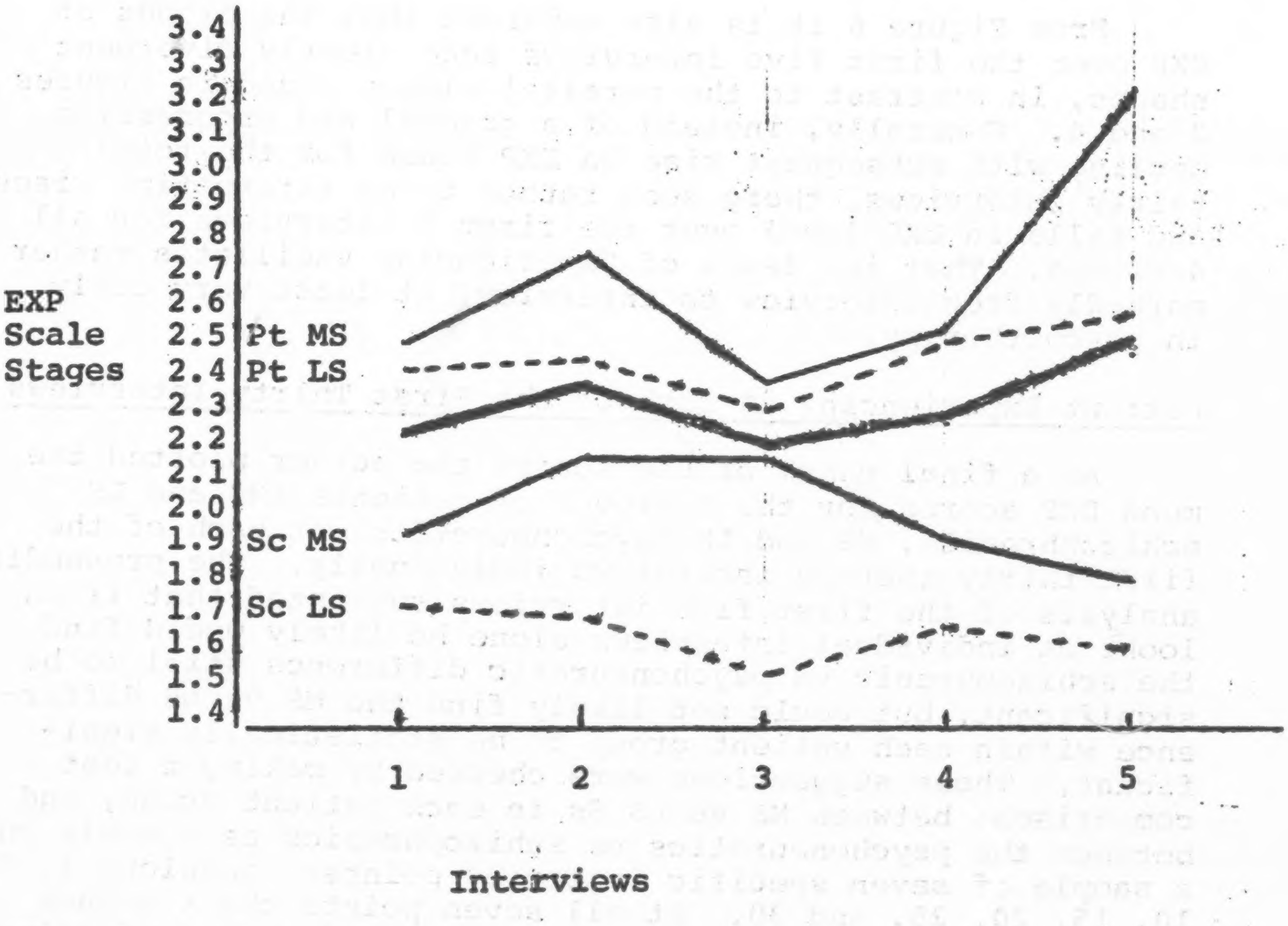
Patient Experiencing at Each of the First Thirty Interviews

As a final check of EXP scores the author plotted the mean EXP scores for the 4 groups of patients (MS and LS schizophrenics, MS and LS psychoneurotics) at each of the first thirty therapy interviews individually. The preceeding analysis of the first five interviews suggested that if one looks at individual interviews alone he likely would find the schizophrenic vs psychoneurotic difference still to be significant, but would not likely find the MS vs LS difference within each patient group to be statistically significant. These suggestions were checked by making t test comparisons between MS vs LS Ss in each patient group, and between the psychoneurotics vs schizophrenics as a whole on a sample of seven specific interview points: sessions 1, 5, 10, 15, 20, 25, and 30. At all seven points the t values were significant at the .05 level or beyond when contrasing the psychoneurotic vs schizophrenic Ss. This suggests that it is quite easy to differentiate the two patient groups by means of their EXP scores, and that samples from a single interview likely will do the job.

One can see this strong schizophrenic vs neurotic differentiation in another way. The frequencies with which the two

Figure 6

Trends of EXP Scale Ratings for the More Successful (MS) vs Less Successful (LS) Psychoneurotic (Pt) vs Schizophrenic (Sc) Patients, over the first five psychotherapy interviews. (n = 6 + 6 for Scs; n = 11 + 11 for Pts--total n = 32).



patient groups respectively obtained scores at the various EXP Scale stages are shown in Table 8. A chi-square analysis of the frequencies revealed that the proportions are statistically different (p .001) for the two groups of patients. The percentages indicate clearly that schizophrenics' scores cluster at the lower end of the scale, while the neurotics do not. Only 12% of schizophrenic scores (obtained anywhere in their first thirty interviews) were higher than 2.5 on the 7-point scale, while 47.5% of psychoneurotic scores were. Virtually no schizophrenic patients received EXP scores at or above level 3 on the Scale, in contrast to 29.5% of psychoneurotic scores. Considering the lower end of the Scale, 51.8% of schizophrenic scores were below 2.0, while only 24.8% of neurotic scores were below 2.0. Generally, the overlap on the EXP Scale stages for the two patient groups tends to be between 1.5 and 3.0. Few schizophrenics get scores higher than 3.0, few psychoneurotics get scores lower than 1.5.

The MS vs LS differentiations by means of EXP scores is much less clearcut when individual sessions alone are considered. T test comparisons were made at the seven specific interview points used above for the MS vs LS schizophrenic and MS vs LS neurotics. In no case were the t values statistically significant. Nevertheless a rather striking consistency was apparent in the EXP scores for these groups if each of the first thirty sessions was considered. The MS cases' EXP means were higher than the means for the LS Ss in 15 of the first 20 interviews for the psychoneurotics, and in 20 of the first 20 interviews for the schizophrenics (both frequencies significant at the .05 level by Sign Test). The trend continued consistently for schizophrenics for the last ten interviews (21st-30th), but not for the neurotics where the MS and LS frequencies for the last ten interviews were equal. The upshot seems to be that if one were to sample any particular interview (among the first twenty sessions), 75% of the time for the psychoneurotics and 100% of the time for the schizophrenics the MS Ss would have higher mean EXP scores than LS Ss. Yet, if one would analyse the scores statistically for a particular interview alone, the MS Ss higher EXP scores would not be statistically significant.

Discussion

Hypothesis 1

The first hypothesis stated that both more-successful schizophrenic and more-successful psychoneurotic patients will show a higher level of Experiencing during the first thirty therapy sessions than will their less-successful

Table 8

Comparison of the Percentages of Scores Obtained at the Various EXP Scale Stages by 26 Psychoneurotic (Pt) vs 12 Schizophrenic (Sc) Patients for 4-minute Samples from Each of the First Thirty Psychotherapy Interviews.

EXP Scale Stages	Percentages	
	Sc	Pt
5.00-5.49	0.0%	.3%
4.50-4.99	0.0	1.5
4.00-4.49	0.0	5.4
3.50-3.99	.6	7.1
3.00-3.49	.6	15.2
2.50-2.99	10.8	18.0
2.00-2.49	29.9	27.7
1.50-1.99	32.5	15.9
1.00-1.49	25.6	8.9
	100.0%	100.0%

counterparts. This relationship between Experiencing and successful outcome has been a consistent finding in previous studies and once again shows up powerfully for the data of the present study. Both more-successful patient groups showed a higher level of Experiencing ($p<.05$) when either the first twenty or first thirty therapy sessions were averaged than did less-successful cases of either group. Further, in both analyses there was no overlap at any of the time points for the four groups of patients. That is, more-successful neurotics had higher EXP levels at all points of therapy (one exception) than did less-successful neurotics, more-successful schizophrenics had higher EXP scores than less-successful schizophrenics, and less-successful neurotics were higher in Experiencing than either schizophrenic group. Although this relationship was not statistically significant when the first five individual interview were averaged, the differentiation was clearcut, again with no overlap of scores among the four groups. Finally, when the means for the four patient groups were plotted for each of the first thirty sessions, the pattern was strikingly consistent for the first twenty interviews for both groups, and for the first thirty interviews for the schizophrenics.

The upshot is that even from the first therapy interview patient Experiencing scores differentiate patients (both psychoneurotic and schizophrenic) who subsequently are dichotomized into more vs less successful therapy cases. Although EXP scores for individual cases fluctuate at all points of therapy, if at any given interview point one averages the EXP scores of more vs less successful cases, the more successful patients show higher levels of Experiencing.

On the other hand, whether or not this consistent differentiation shows up as statistically significant seems to be a function of several factors. Obviously the larger the subject sample the more likely statistical significance will occur. The more reliable and valid the outcome differentiations the more likely significant results. But in addition, the data of this study suggest that the more individual samples of Experiencing one averages the more likely the outcome differences will be statistically significant.

Hypotheses 2 and 3

These hypotheses will be discussed together since they are quite similar. The second hypothesis stated that both more-successful schizophrenic and more-successful psychoneurotic patients will show more positive change in Experiencing over the first thirty therapy session than will their less-successful counterparts. It's clear from above that more-successful cases have higher levels of Experiencing at all points of therapy. Hypothesis 2, however, focuses on the question: Do more successful cases show a consistently greater change toward deeper levels of Experiencing as therapy progresses?

The data of the present study offer no support for this hypothesis, whether the first five, first twenty, or first thirty interviews are considered. One cannot differentiate cases of more vs less successful outcome (either schizophrenics or neurotics) by the shape or slope of EXP scores over the therapy sessions.

Since the sampling of sessions in this study was quite exhaustive of the particular therapy interactions, it seems this finding is relatively powerful. It suggests that previous studies finding differences in Experiencing change over therapy (Tomlinson, 1962, 1967; Van der Veen, 1965, 1967; Ryan, 1966) were perhaps misleading since each of them sampled only several interview points across the total therapy sequence. In any case, the intensive sampling of this study found no evidence for differential change in Experiencing early to late in therapy for more vs less successful cases.

The evidence is similar for the third hypothesis, which predicted that the amount of positive change in Experiencing over the first thirty therapy interviews will be significantly greater for more-successful psychoneurotic than for more-successful schizophrenic patients. None of the analyses of the present study offered any support for this expectation. More successful psychoneurotic patients, despite the fact that they are functioning at higher and more appropriate levels of Experiencing (there is no evidence of a ceiling effect in the present data) nevertheless show no more improvement in Experiencing than do more-successful schizophrenic cases.

It seems necessary to point out regarding both Hypotheses 2 and 3 that the total therapy sequence was not sampled for many of the cases since 25 of the 38 cases had interviews beyond the 30th. A consequence of this is that the later portions of therapy were not sampled at all for some of the cases. On the other hand, 15 of 26 neurotics and 5 of 12 schizophrenics had a total of 40 interviews or less; and 19 of 26 neurotics and 8 of 12 schizophrenics had a total of 50 interviews of less. Hence for 53% of the cases at least 75% of the total therapy interaction was sampled, and for 71% of the cases at least 60% of the total sessions was sampled--substantial blocks of the total psychotherapy. The fact, therefore, that Experiencing change is not related to more-successful outcome in this study seems a finding of considerable generality.

Despite this, there is some gnawing evidence that Experiencing change seems to occur in therapy. Individual subjects' scores vacillate, in some cases rather markedly. Further, at least for psychoneurotics there is a clear positive linear slope of Experiencing within particular therapy sessions (Kiesler et al., 1965). These facts lead one to cling to the possibility that the Experiencing Scale is sensitive to changes over the entire therapy sequence. If real changes are present for MS cases, however, one has to conclude that the random sampling procedure used in this and previous studies somehow is inadequate. The alternative is some type of systematic sampling wherein the sequence of Experiencing over specific topic, problem or thematic areas is systematically tapped by prior editing of the total taped sessions; or where the "high" points (specified by the therapist or some other criterion) of the interaction between therapist and patient are pinpointed and sampled. On the other hand, random sampling is consistent with Rogers' theoretical statement--that change in patient process is gradual and cumulative as well as pervasive at every stage of the interaction, regardless of interview content.

Finally, it is important to emphasize that reliable change in Experiencing did occur for the subjects of the present study, but the change was independent of patient type and outcome. The shape or slope of Experiencing over both the first twenty and first thirty sessions was statistically reliable ($p < .05$) for all 38 cases as a whole. This indicates that patients in individual psychotherapy (psychoneurotics and schizophrenics, more or less successful outcomes) tend to show the same trend in Experiencing change over the first thirty therapy sessions. The slope is U-shaped over the first twenty interviews, with a subsequent drop in Experiencing from the 20th to the 30th interviews--i.e. the slope shows an inverted cubic function when the total 30 sessions are considered. All patients initially tend to drop in Experiencing after the first therapy interview, continue to drop until about the 15th interview, recover to about the 20th session, and finally show a gradual decrease to the 30th. Generally, if one samples randomly from each individual session and averages Experiencing level over several sessions (in the present study successive blocks of 5 interviews were averaged), the resulting pattern of Experiencing is a gradual change from higher to lower back to higher back to lower levels of Experiencing. This suggests it is unlikely that a patient can maintain a consistently high level of Experiencing during therapy, but rather that successive backsliding with subsequent recovery seems typical.

Hypothesis 4

The fourth hypothesis stated that the level of Experiencing during the first thirty psychotherapy sessions will be significantly higher for psychoneurotic in contrast to schizophrenic cases, regardless of outcome. This hypothesis received the strongest support from the data of the present study. Analyses of the first five, first twenty, and first thirty sessions all consistently revealed statistically significant ($p < .01$) differences showing that psychoneurotics function at higher levels of Experiencing than schizophrenics. Although hardly a remarkable finding from an a priori basis, it is heartening to find the empirical evidence so clearcut. There is no overlap at all at any of the interview time points, in that even the less-successful psychoneurotics consistently score higher than the more-successful schizophrenics. Further, this consistency is apparent at each of the 30 individual interview points. The upshot seems clear: Insofar as level of Experiencing is concerned, schizophrenics and psychoneurotics in individual psychotherapy are playing in different ballparks. Previous studies are in agreement with this conclusion.

Conclusion

It seems appropriate to summarize briefly the more pertinent boundary conditions of the present study. The patient groups seem clearly distinct--a group of moderately chronic hospitalized schizophrenics and a group of outpatient university psychoneurotics, of both sexes although males predominate by far. Both groups of patients were participants in large-scale research projects placing additional time and task demands upon them. The outcome criteria used were somewhat limited and divergent--psychometric pre to post change predominated for the schizophrenic more vs less successful differentiation, while therapists' judgments of pre to post improvement constituted the criterion for psychoneurotic cases. Therapists of the two research projects covered a relatively broad "school" range for the time of the original studies--the schizophrenics' therapists were predominantly Rogerian in orientation, while the neurotics' therapists were a mixture of Rogerian, Adlerian, neo-Freudian, and eclectic backgrounds; of both sexes, although

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males predominated for both studies. In other words, the patient groups were distinct, the measures of outcome were divergent, and the orientations of the therapists represent a wide cross-section of the traditional verbal psychotherapies.

Despite these major differences, a consistent pattern of results emerged. Generally, the findings of the present study solidify previous evidence for the validity of the Experiencing construct and of its operational statement, the Experiencing Scale. Experiencing clearly differentiates gross diagnostic groups' functioning in therapy, with psychoneurotics attaining deeper levels than schizophrenics. Experiencing continues to be related to more successful outcome, as defined by various independent criteria, for both schizophrenic and psychoneurotic cases. Importantly, level of Experiencing alone seem to account for these relationships, suggesting that what is being measured by the scale is more similar to an expressive trait, rather than state variable. Finally, the evidence to date is clearly against change in Experiencing being an important component in successful therapy, although alternate sampling procedures should be considered before this conclusion is accepted as final.

C. Self-interview Experiencing and Eysenck's Personality Factors Among Psychoneurotic and Normal Student Groups

The present study appraises the relationship between in-therapy Experiencing (Rogers, 1957, 1959; Rogers et al., 1967; Gendlin, 1962) and personality characteristics of patients coming to psychotherapy. When one searches for relevant personality variables for Experiencing it becomes clear there is little theory or research to direct one's path. Rogers and other psychotherapy theorists have consistently ignored patient (and therapist) individual difference factors in their formulations (Kiesler, 1966; 1969; 1970). As a result one is forced to fall back upon clinical lore, the personality research literature, and his own hunches as sources for extrapolating relevant personality factors.

The author's clinical experience has increasingly convinced him that the currently loosely defined categories of "hysteria" and "obsession-compulsion" represent meaningful subcategories of the psychoneurotic population having direct implications for subsequent psychotherapeutic treatment. Eysenck (1953, 1957) for some time has advocated a similar emphasis with his personality questionnaire differentiation of "hysterics" and "dysthymics." He operationalizes these conceptions by two questionnaire scales, Neuroticism (N) and Extraversion-Introversion (E), on the Maudsley Personality Inventory (MPI) (Eysenck, 1959) and more recently on the Eysenck Personality Inventory (Eysenck, 1964).

There is considerable converging evidence present in the questionnaire literature which supports the validity of Eysenck's two basic personality dimensions as economically descriptive and representative of non-psychotic populations (for Eysenck "psychoticism" is a third orthogonal factor). Continued research interest has been maintained in the two basic personality constructs of neuroticism (also called general anxiety or emotionality) and extraversion-introversion. Wiggins (1968) summarizes the converging trends in this enormous body of research. "If consensus exists within the realm of temperament structure, it does so with respect to the importance of the large, ubiquitous, and almost unavoidable dimensions of extraversion and anxiety (neuroticism). The most systematic recognition of the primacy of these two dimensions may be found in the concentration of Eysenck and associates (Eysenck, 1953, 1957,) on the E (Extraversion) and N (neuroticism) scales of the MPI (Eysenck, 1959) and the more recent Eysenck Personality

Inventory (Eysenck, 1964). In the somewhat broader-based research of Cattell and associates (Cattell, 1957, 1965; Cattell & Warburton, 1967; Hundleby, Pawlick, & Cattell, 1965), extraversion (UI 32) and anxiety (UI 24) emerge as second-order factors in L (behavior ratings) and Q (questionnaire) data, and as first-order factors in T (objective test) data. These dimensions are represented in Guilford's (1959) work by the R (rhathymia) and C (emotional stability) factor scales. Second-order factors of Gough's (1957) CPI are very similar to the second-order anxiety and extraversion factors of Cattell's (1964) 16 PF questionnaire (Mitchell, 1963). The first two factors of the MMPI are now interpreted by some workers (Corah, 1964; Kassenbaum, Couch, and Slater, 1959) as neuroticism and extraversion, respectively.

"American workers, other than Cattell, have focused on various substantative interpretations of these dimensions with considerably less concern for their factorial properties or relations to general systems of personality structure. The dimension of neuroticism, for example, has received attention in research programs devoted to "manifest anxiety" (Taylor, 1953), "sensitization-repression" (Byrne, 1964), and "social desirability" (Edwards, 1957). Although stemming from quite diverse conceptual interests, these research programs show a commom pool of items (MMPI) that provides operational definitions of their constructs." (Wiggins, 1968, pp. 309-310).

Eysenck (1953) began his program of research with large scale factor analytic studies using a wide variety of questionnaires, objective behavior tests, and physiological measures in order to discover certain basic and pervasive dimensions of personality. He amassed evidence for two such orthogonal dimensions in the nonpsychotic population.

The theoretical structure Eysenck built around these two basic dimensions is a creative combination of Pavlovian, Jungian, and Hullian hypothetical constructs. Pavlov's theory of cortical functioning emphasizes two basic cortical processes, "excitation" and "inhibition." These terms are hypothetical constructs of an imprecise neurophysiological nature, both of which are positive in nature and function. Franks (1962) states, "Inhibition . . . is not regarded as merely the absence of excitation . . . It should be stressed that cortical inhibition in the Pavlovian sense . . . should be associated with the absence of behavior inhibition in the psychiatric sense." (p. 460). Pavlov suggested that hysterics and dysthymics differed in terms of the excitation-inhibition ratio, the neurasthenic being at the excitation-dominated end of the continuum and the hysteric at the inhibition-dominated end. This dimension is highly speculative, being located centrally, and its existence is inferred largely from peripheral observations made at the behavioral level. Jung (1924) suggested further that the characteristic neurosis of the extravert is hysteria, whereas that of the introvert is psychasthenia. He also stressed the essential independence of introversion-extraversion from neuroticism.

These ideas were systematized and extended by Eysenck (1953, 1957). He noted that the behavior of patients usually included in the two broad clinical categories of hysteria and dysthymia lends support to the assumption that dysthymia is related to excessive cortical excitation, while hysteria and psychopathy are associated with excessive cortical inhibition. Dysthymics tend to present the following types of symptoms: anxiety, compulsive thoughts and actions, oversensitivity to his environment, overcaution, hesitancy, hyperactivity, overconscientiousness, irritability, introspection, and he is often ill at ease and agitated. All these characteristics are consistent with a presumed state of exaggeration of the central excitation process. On the other hand, the hysteric tends to be lacking in the above qualities, is more likely to be impulsive, irresponsible and unreliable, to be insensitive to his environment and to the feelings of other people, and his responsiveness to his environment tends to be superficial and indiscriminatory. His abnormalities are more likely to be of a dissociative character such as fugues, escape mechanisms, and other conversion symptoms. These characteristics would seem highly consistent with a presumed state of predominantly cortical inhibition.

As Franks (1962) recapitulates Eysenck's thinking, "It seems, therefore, that both behaviorally and symptomatically neurotics differ from each other along the dimension of introversion-extraversion; and that the underlying central concomitant, presumably constitutional, may be found in the changing balance of the excitation-inhibition ratio, ranging from a predominance of excitation at the introverted (dysthymic) end to a predominance of inhibition at the extraverted (hysterico-psychopathic) end. If this is so, then an excitation-inhibition postulate should be tenable in accounting for many of the behavioral differences observed in normal introverts and extraverts." (p. 461). In other words, the introverted normal and the dysthymic have similar behavioral characteristics, but the normal lacks the high neurotic (emotional) drive of the dysthymic. Similarly, the extraverted normal resembles the hysteric, but does not have his neurotic (emotional) drive.

Eysenck's hypothesis is that in extraverts cortical inhibition is generalized more quickly and strongly and dissipated more slowly than in intorverts. He next expanded the theory in more testable directions by applying and translating this general principle to learning phenomena. The resulting central postulate is that conditionability or learning is related not to the degree of neuroticism present, but centrally to the hypothetical excitation-inhibition balance, and behaviorally to the introversion-extraversion balance of the individual concerned (Eysenck, 1957). An introverted subject, whether neurotic or normal, should form conditioned responese readily; and these responses, once formed, should be difficult to extinguish. For example, through excessively strong and persisting conditioned response mechanisms, fear reactions in the dysthymic become conditioned response patterns to stimuli which are innocuous and neutral for other individuals. Thus, the excessive amount of fear which is so characteristic of dysthymics becomes a generalized and persistent response pattern. Conversely, an extraverted subject, whether neurotic or normal, should form conditioned responses poorly; and these responses, once formed, should extinguish readily.

The evidence to date regarding this central learning postulate is far from clearcut. A lively debate ensued in the last decade with Eysenck on one side and Janet Spence on the other. Eysenck and his followers, as stated above, believe that extraversion-introversion rather than anxiety (or neuroticism) is closely related to rate of conditioning and extinction, while a number of investigators led by Spence claim just the opposite. Recent statements of the two positions are summarized by Eysenck (1962) and J. T. Spence (1963). Most of the disagreement arises from different points of view regarding the interpretation of Eysenck's E and N scales as compared with the MAS. Eysenck interprets the high correlation between MAS and N (about .80) and the moderate correlation between MAS and E (about -.30) as evidence of the impurity of MAS, although the correlation between MAS and E is hardly sufficient to explain away the generally positive findings concerning MAS and conditioning. Furthermore, as Spence points out, the correlation between performance in conditioning experiments and the E scale are not greater in magnitude than those obtained with the MAS. To date the issue is still undecided.

Eysenck's general learning postulate has been extended beyond the processes of conditioning and extinction. He speculates that Hull's concept of "reactive inhibition" is an intervening variable on which introverts and extraverts should differ. Since cortical inhibition is generated more strongly and dissipated more slowly in extraverts than in introverts, extraverts should develop more reactive inhibition and dispel it more slowly than introverts, and should be more susceptible than introverts to the development of neural satiation. Further Eysenck's research has attempted to demonstrate that differences in extraversion introversion are related to differences in kinesthetic figural aftereffect, a phenomenon attributed to neural satiation. Then, assuming that reminiscence is a measure of reactive inhibition, Eysenck predicts that extraverts should show a higher degree of the reminiscence phenomenon (e.g., in pursuit rotor learning) than should introverts. Also the hypothesized propensity of extraverts to have stronger inhibition functions leads to the prediction that they will become more satiated or tired on repetitive tasks than will introverts. For example, he has shown that extraverts have more involuntary rest pauses during massed practice on a tapping task. He reports significant relationships in accord with his theory in studies of problem solving and time-estimation. More recently (Eysenck, 1963) he has spelled out the implications of his theory for drug effects. He argues that since extraverts develop inhibition more readily, they should be little affected by stimulant drugs, but should over-react to small doses of depressants; while introverts should show the reverse effect. Furthermore, regardless of initial position on the extraversion-introversion dimension, stimulants should produce a shift toward introversion, depressants a shift toward extraversion.

Wiggins (1968) summarizes the broad experimental thrust of Eysenck's theory by outlining the prolific research emanating from it. "Recent studies of the E scale of the Maudsley have dealt with clinical (Armstrong et al., 1967; Caine et al., 1964; Ingham & Robinson, 1964) and occupational (Rao, 1966) groups and general personality correlates (Farley & Farley, 1967; Knapp, 1965; Venables, 1965). The E scale has been related to learning (Purhit, 1966), conditioning (Eysenck, 1965; Franks & Mantell, 1966; McPherson, 1965), problem solving (Farley, 1966) and a variety of perceptual motor tasks (Eysenck & Levey, 1965; Farley, 1966; Howarth, 1964; Knowles & Krasner, 1965; Yates & Laszlo, 1966). The scale has been studied in relation to speech (Ramsay, 1966), self-ratings (Vingoe, 1966) and salivary activity (Eysenck & Eysenck, 1967). There has been concern with the dimensionality of the E scale (Sparrow & Ross, 1964), its cross-cultural generality (Rafi, 1965), and sex differences (Gutman, 1966; Hannah, Stom, & Caird, 1965). The general construct of extraversion has been investigated with other instruments (Allen, Richer, & Plotnik, 1964; Corah, 1964; Haertzen & Miner, 1965; Rossi & Solomon, 1965) and cross-media matching has been attempted (Hallworth, 1965; Hallworth & Davies, 1964)." (pp. 311-312).

Evaluation of Eysenck's Theory

Franks (1962) itemizes several weaknesses of the cortical excitation-inhibition theory proposed by Eysenck. "The theory . . . suffers from many temporary weaknesses, not least of which are a present lack of extensive confirmatory data, and the possibly premature assumption of a general factor of conditionability, the reality of which has yet to be demonstrated . . . A further weakness unfortunately common to almost all studies involving personality variables, is the diminutive magnitude of the obtained correlations between conditioning and those measures of personality to which conditionability is believed to be related. . . Another weakness . . . is that certain of the findings may relate not to classical conditioning, as it is generally (but not universally) defined, but only to behavioral changes at peripheral levels. . . Nevertheless, the present theory provides many fundamental advantages which more than compensate for the existence of numerous weaknesses, none of which are devastating and all of which can be remedied. The theory is so formulated that it permits of predictions which can be explicitly tested in a variety of different situations and with a variety of . . . techniques." (p. 481).

Perhaps the most concise evaluation of Eysenck's prodigious work to date is that of Klein, Barr, and Wolitzky (1967). "How then to assess Eysenck's theories and the considerable body of research they have stimulated: The theories represent a leap from higher to deeper levels of functioning, and many of the reported findings, especially by Eysenck and his students, appear to support these theories. There are, however, many contradictory findings, which he often dismisses too glibly; and the most glaring lack is in physiological studies that might deal more directly with the issues. These may be forthcoming with increased knowledge in the area, and the drug studies represent an attempt in that direction. An encouraging aspect, to us, is the fact that contradictory findings have often stimulated Eysenck not only to clarify his concepts, but to explore the relevant parameters of the laboratory tasks." (p. 503)

Rationale for the Present Study

For purposes of the present study it's important to point out several characteristics of Eysenck's research. First, his original formulations and research (1953) dealt with psychoneurotic samples and emphasized more strongly the behavior of "hysteric" and "dysthymic" psychoneurotic subjects. His later experimental research has been done primarily with normal samples--although several studies have explored further the factorial structure of personality using the E and N scales on psychoneurotic and other clinical groups. Secondly, his original formulations emphasized the interaction of the two factorial questionnaire dimensions (N and E-I) as essential for explaining psychoneurotic behavior. Most of his later research, in contrast, has focused on the E-I dimension alone. This is consistent with his notion that the excitation-inhibition balance should account for many of the behavioral differences observed in normal introverts and extraverts. As stated previously, the introverted normal and dysthymic have similar behavioral characteristics, but the normal lacks the high neurotic drive of the dysthymic; while the extraveted normal resembles the hysteric, but does not have his neurotic drive. In other words, the predictions from excitation-inhibition theory have to do with the extraversion-introversion dimension, and are unrelated to the neuroticism dimension, except that high scores on neuroticism may exacerbate converse behaviors on the E-I dimension.

This author feels that the large body of Eysenck's research focusing on the E-I dimension alone on normal subjects is perhaps unfortunate. It seems plausible, particularly in light of the low correlation values obtained for normal subjects, that hypothesized differences might show up more clearly on psychoneurotic subjects. Further, and more importantly, it seems that the interaction of the N and E-I dimensions might be crucial in determining the hypothesized differential responses. If this is the case, it argues for research using both the N and E Maudsley scales, but importantly where the two factors are combined in factorial designs. Eysenck, using normal subjects, has looked at high (extraverts) and low (introvert) E subjects, both of whom are low on the N scale. He has tended, therefore, to ignore his original clinical groups of dysthymics and hysterics, both high on the N scale, with hysterics additionally high on E, dysthymics additionally low on the E scale.

The present study concerns itself primarily with the possible combinations of Eysenck's two factorial dimensions (N and EI) as they are related to patient in-therapy experiencing. Instead of studying extraverts vs introverts, the study will look at four personality groups, defined operationally by the N and E scales. The four groups are: "hysteric" (high N, high E), "obsessives"[5] (high N, low E), normal hysterics (low N, high E(, and normal obsessives (low N, low E,). To assure selection of subjects to fill in these four groups, two populations will be sampled: the first university out-patient psychoneurotics, the second normal university undergraduates.

The sample of within-therapy Experiencing will be extracted from subjects' self-interviews (Gilbert, 1959) wherein they talk about themselves in important areas of their life to a tape recorder in a room by themselves. The self-interview task was chosen, instead of, for example, initial therapy sessions, primarily to eliminate from subjects' talking behavior multifaceted confounding variance that would be contributed by the presence of different therapists. That is, the self-interview procedure in effect standardizes the self-report verbal task for the subjects by eliminating the confounding presence of a therapist or of different therapists.

Choice of this standardized procedure, on the other hand, moves the study in a therapy-analogue direction, since the task is not dyadic as in therapy. Moreover, the mere presence of a therapist with the subject may markedly influence the quality of self-verbalization elicited (Colby, 1960). It seems wise to keep in mind the possible attenuating effects of this somewhat artificial analogue task when the results are considered later.

Predictions for the Study

Predictions regarding the quality of Experiencing behavior from Eysenck's cortical excitation-inhibition theory are far from clear-cut. In Eysenck's theory an introverted subject (in contrast to the extravert), whether neurotic or normal, should form conditioned responses more readily which should extinguish more slowly; should develop less reactive inhibition and dispel it more quickly; should show a lower degree of the reminiscence phenomenon in learning situations; should be less susceptible to the development of neural satiation; and should be more affected by stimulant and less affected by depressant drugs.

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[5] Throughout the remainder of this study the author will use the term "obsessive" instead of Eysenck's "dysthymic." This decision is mostly arbitrary, but reflects more clearly the author's bias regarding what is measured by high E and low EI scores.

Despite these theoretical characterizations, however, this author found it difficult to derive which group of subjects (hysteric or obsessive) would show a greater degree of closeness to their feelings, of focusing on and elaborating them when talking about themselves in therapy.

The clinical descriptions of hysterics and obsessives offer little more assistance. The obsessive is characterized primarily as one who spends a lot of time with his private thoughts, being quite introspective, giving considerable thought to the effect of his behavior on others, is quite anxious and overconscientious. On the other hand the hysteric tends to be at the opposite end of these behavioral continua--i.e. spends little time probing his inner feelings and motives, little time introspecting about things generally, is less consciously anxious, tends to be insensitive to the effects of his behavior on others, is more impulsive and action-oriented.

Since obsessive or introverted subjects are closer to and more familiar with their internal life, it seems reasonable to expect that they might be closer to their feelings and attitudes than hysterics, might more easily report the contents of their inner experience--might show higher and deeper levels of Experiencing in therapy. On the other hand, one of the traditionally emphasized aspects of the obssessive is his over-intellectualized, controlled, and rigid thinking processes, which consequently tend to isolate or ignore his own personal reactions. This aspect would, of course, predict less ability to Experience in therapy for the dysthymic. In addition, the hysteric, although utilizing repressive and denial mechanisms (which would predict a low level of Experiencing), is known for his highly emotional (although often bland) and histrionic flair, his sharp impressions of himself and others in some areas--which would predict a higher level of Experiencing for the hysteric. Another equally plausible hypothesis is that neither the hysteric nor the obsessive will show superiority in therapeutic Experiencing, since their defensive processes, admittedly drastically different for each, make it equally unlikely for either to focus on his feelings and attitudes--the obsessive isolating and intellectualizing his feelings, the hysteric repressing, denying, and dissociating his feelings.

The upshot seems to be that clear-cut predictions regarding in-therapy Experiencing are not possible for the Eysenck normal and psychoneurotic personality groups. Regardless, it seems quite important to examine the possible relationships even on an exploratory basis. Eysenck's personality factors seem to pervade the personality research literature. The construct validity of Experiencing would be considerably expanded if relationships can be established in the individual differences domain. These seem reason enough for examining empirically the relationship between Experiencing and Eysenck's personality groups, which is the purpose of the present study.

Method

Subjects. Two populations were sampled for the present study. The first, a group of normals, consisted of University of Iowa introductory psychology undergraduate students. An original pool of 518 subjects (250 males, 268 females) were administered in groups a battery of questionnaires as part of their research participation requirement. From this original sample, a final sample of Ss was selected on the basis of the Ss' Bendig Emotionality (E) and Social Extraversion-Introversion (EI) scores, yielding four Eysenck personality groups for each sex distributed as follows:

	E	EI	Personality Group	n M	 F
Group 1	Hi	Hi	Normal Hysterics	12	12
Group 2	Hi	Lo	Normal Obsessives	12	12
Group 3	Lo	Hi	Normal Extraverts	10	10
Group 4	Lo	Lo	Normal Introverts	10	10
				44	44

Thus, the final sample of normal undergraduates for this study consisted of 44 males and 44 females, a total of 88 Ss. This sample will hereafter be referred to as the UNG (undergraduate) Ss.

The second population was that of University of Iowa undergraduate and graduate students applying for psychotherapeutic services at the University Counseling Service.[6] During the academic year 1966-67 any client who, on initial contact, checked the "personal problem" category (in contrast to "vocational" or "educational" problem), and who subsequently agreed to the intake interviewers' request to participate in the research project became a subject for the present study. As a result of this proceudre 110 clients initiated the research project. However, since 17 of these Ss did not complete all the research tasks, the final sample consisted of 93 male and female clients with personal problems, subsequently subdivided by their Bendig E and EI scores into the following groups:

	E	EI	Personality Group	M	F
Group 5	Hi	Hi	Hysterics	17	18
Group 6	Hi	Lo	Obsessives	29	19
Group 7	Lo	Hi & Lo	Mixed Neurotics	5	5
				51	42

Because of the very small Ns in Group 7 (mixed neurotics) these 10 Ss are not included in any of the later analyses. It is interesting that these obtained distributions on the Bendig scales are consistent with the expectations from Eysenck's theory. In a counseling service "emotionally disturbed" population one should not find many Ss with low E (neuroticism) scores.

For convenience of analysis the four remaining groups of Ss (male and female UCS obsessives, male and female UCS hysterics) were reduced by table of random numbers to equal size, each with 17 subjects. Hence the final sample of psychoneurotic clients, hereafter referred to as UCS Ss, consists of 17 male hysterics, 17 male obsessives, 17 female hysterics, and 17 female obsessives a total of 68 UCS Ss.

The two final samples for the present study, then consisted of 44 male and 44 female UNG Ss and 34 male and 34 female UCS Ss, a total of 156 Ss. The UNG Ss were further subdivided into Eysenck's four personality groups by their

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[6] The author expresses his appreciation to Drs. Willis Poland, Acting Director and John Crites, Director of the University of Iowa Counseling Service for permitting the author to conduct the study on the UCS clientele.

Bendig E and EI scores, while the UCS clients were subsequently separated into two Eysenck groups. Table 9 presents the means and standard deviations of the age scores for the two samples of subjects for the study.

It's important to point out that the two separate samples (UNG and UCS) yield three distinct pairs of Eysenck personality groups. The undergraduate normal sample yields two pairs of Eysenck's groups. The first pair includes the "normal (UNG) obsessives" and "normal (UNG) hysterics." These groups are somewhat unusual in Eysenck's conception since their high emotionality (neuroticism) scores indicate they belong to the psychoneurotic population; whereas in this study they are referred to as normal since, despite the fact that their high Bendig E scores suggest they have emotional problems, they have not publicly acknowledged this by coming to an outpatient agency for therapeutic assistance with their problems. The second pair are the "normal (UNG) introverts" and "normal (UNG) extravetts." This pair is consistent with Eysenck's conceptualization of non-neurotic subjects, since both groups' E (neuroticism) scores are low. Finally, the counseling service (UCS) sample provides the pair of "UCS obsessives" and "UCS hysterics." These groups are also consistent with Eysenck's notions in that their E (neuroticism) scores are high suggesting psychoneurotic status, and their overt behavior has acknowledged this status by their coming to the UCS outpatient agency for assistance with personal problems.

The potential confusion in later discussion, therefore, lies with the subtle distinction between "UNG obsessives" vs "UCS obsessives" and between "UNG hysterics" vs "UCS hysterics." Both UNG and UCS groups have high Bendig E (neuroticism) scores, suggesting emotional problems for both. The UNG and UCS groups differ, however, in that only the latter groups have publicly acknowledged psychoneurotic status by coming to the university counseling service for assistance. Theoretically, there should be no behavioral differences (except perhaps in degree) between the respective UNG and UCS groups since their operational assessments yield quite similar E and EI scores. On the other hand, it is possible that the additional factor of motivation for, or expectancy of, help in the UCS Ss may produce differential results. Subsequent analyses will permit an answer to this question.

Procedure. Both the UNG and UCS Ss participated in the two tasks of the Study: 1) completion of the questionnaire battery, and 2) performing the Gilbert Self-interview, although in slightly different circumstances.

Table 9

Means and Standard Deviations of the Age Scores for the UNG and UCS Ss of the Study.

Undergraduate (UNG) Sample:				Age Scores			
				Males		Females	
	E	EI	Personality Group	$\bar{X}$	SD	$\bar{X}$	SD
Group 1	Hi	Hi	Normal Hysterics	19.1	.99	19.7	2.58
Group 2	Hi	Lo	Normal Obsessives	19.4	.84	20.0	2.21
Group 3	Lo	Hi	Normal Extroverts	19.8	.79	19.3	.68
Group 4	Lo	Lo	Normal Introverts	20.3	2.31	19.0	0.00

Counseling Service (UCS) Sample:				Age Scores			
				Males		Females	
	E	EI	Personality Group	$\bar{X}$	SD	$\bar{X}$	SD
Group 5	Hi	Hi	Hysterics	23.5	5.91	19.7	5.09
Group 6	Hi	Lo	Obsessives	22.4	4.05	21.2	2.56

1) Test Battery. The questionnaire battery consisted of the following instruments. a) A Personal Information Inventory was administered which asked for name, age, year in college, sex, and father and mother's level of education, and annual income. From this inventory later analyses use the data of sex and a modification of Hollingshead & Redlich's Index of Social Position (1958, pp. 390-394). For the present study their residence scale was inapplicable, so that the final socioeconomic status (SE) rating for the present Ss was estimated by the following formula: SE = 2 O + 1 E--where O was calculated by Hollingshead & Redlich's 7-point occupational scale, and E by their 7-point educational scale (in both scales 1 is the high end, 7 the low). The possible range of scores for this modified SE rating are from 3 (highest socioeconomic class rating) to 21 (lowest class rating).

b) The second part of the battery consisted of Bendig's Pittsburg Social Extraversion-Introversion (EI) and Emotionality (E) Scale (Bendig, 1962), a modification of Eysenck's Maudsley Personality Inventory (Eysenck, 1959) for use with U.S. undergraduate populations. The Bendig E and EI scores were used to separate the UNG and UCS male and female samples into Eysenck's personality groups. Table 10 presents the E and EI means and SDs for the various subgroups. For both the UNG and UCS samples it was possible to use the means reported by Bendig for his normative sample (E = 14.2 (males), 14.6 (females); EI = 17.6 (males), 17.2 (females)) to dichotomize the Ss into Hi and Lo groups for each scale. E scores 15 or higher and EI scores 17 or higher were considered Hi; E scores 14 or lower and EI scores 16 or lower were considered Lo. The workability of the mean as the cutting score for the present samples is further support for Eysenck's contention that the E and EI factors are orthogonal. For the UNG sample it was possible to fill all four personality cells, and for the UCS sample it was possible to fill the two personality cells which were theoretically congruent. The correlations between E and EI ranged from -.02 to -37 for the UNG and UCS male and female samples. From Table 10 it is clear that the various Hi and Lo E and EI groups are distinct, and that each group high on one factor (say E) has little overlap with any group low on that same factor (E).

c) The third part of the test battery consisted of the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) as a measure of social desirability response set, and Couch & Keniston's abbreviated version of the "Yeasayer-Naysayer Scale (Couch & Keniston, 1960) as a measure of response acquiescience set.

Table 10

Means and Standard Deviations for the 4 UCS Personality Groups (N = 68) and 8 UNG Personality Groups (N = 88) for the Bendig E (Emotionality or Neuroticism) and EI (Extroversion-Introversion) Scores

UCS Ss:	Bendig Scores:			Means		SDs	
	E	EI	n	E	EI	E	EI
Males	Hi	Hi	17	23.8	19.4	3.13	2.80
	Hi	Lo	17	23.1	7.3	5.54	4.70
Females	Hi	Hi	17	23.5	19.9	3.99	2.18
	Hi	Lo	17	22.2	8.9	4.16	3.45
			68				

UNG Ss:				Means		SDs	
	E	EI	n	E	EI	E	EI
Males	Hi	Hi	12	24.2	25.0	2.14	1.70
	Hi	Lo	12	26.7	8.6	2.23	4.48
	Lo	Hi	10	7.3	27.1	2.83	1.97
	Lo	Lo	10	8.8	9.7	2.66	3.65
Females	Hi	Hi	12	24.7	25.7	2.35	1.78
	Hi	Lo	12	26.1	7.3	3.12	3.31
	Lo	Hi	10	7.5	27.8	2.64	1.55
	Lo	Lo	10	9.9	10.7	4.23	4.42
			88				

d) The final part of the test battery consisted of Barrett-Lennard's Relationship Inventory (Barrett-Lennard, 1962) which measures the client's perception of Rogers' "necessary and sufficient" therapist conditions--the therapist's relationship attitudes of positive regard (R), empathic understanding (E), and congruence (C).[7] Both the UNG and UCS samples answered the Relationship Inventory with explicit instructions to describe their "ideal therapist," as elaborated below. From the RI assessment a single score is reported in later analyses, which is the total of R + E + C.

The UCS Ss individually took the test battery as part of the routine intake battery given to all clients applying to the University of Iowa Counseling Service. The research battery was not identified to the clients as separate from the usual clinical battery. In contrast, the original sample of 518 UNG Ss were administered the test battery in groups of approximately 40 at a time. These UNG Ss before filling in the questionnaires, were read the following instructions by a male research assistant:

> You have been asked to come here today (tonight) for two reasons. The first task we want you to do requires about 20 minutes---the second about 15 minutes. When you have completed both you may leave.
>
> The first task requires that you answer some personal questions about yourself. Of course it's easy for you to answer these questions inaccurately or in a purely random fashion, but we ask that you try to answer them as sincerely as possible. This information is kept completely confidential and is used for research purposes only. I will now

---

[7] Barrett-Lennard's RI provides two additional scores, "unconditionality of regard" (U) and "willingness to be known" (W). The intercorrelation pattern for the present samples suggested that R, E, and C belonged to the same cluster, while U and R represented two separate factors. To obtain a purer and more homogeneous measure of Rogers' conditions, it was decided to eliminate the U and R scores from the analyses for this study.

> pass out two sets of questions to you. Read the instructions for both sets. If you have any questions I will be happy to answer them. (Pass out questionnaires). . . . Are there any questions? Go ahead then and please answer every question. When you are finished turn over your papers. As soon as everyone is finished we will begin the second part.
>
> . . . The second task requires that you answer some more questions. But this time the questions are not about you. We are interested in how the general public pictures the ideal psychotherapist in action. In answering the questions I will hand out to you, we would like you to assume that you are in psychotherapy. You have had several sessions with your therapist. You feel that this therapist is ideal--interacts with you in every way exactly as you desire. In other words, insofar as you are concerned he is a perfect, ideal therapist. We would like you to answer the questions that will be given you with this set in mind. That is, answer all the questions according to how you feel your ideal therapist would behave. Look over the instructions, and if there are any questions, please ask. (Pass out questionnaire) . . . Are there any questions? OK, please answer every quesion. When you are finished bring your papers to me, and you may leave.

The UCS clients had similar instructions for the Relationship Inventory which they filled in individually, as part of their routine test battery:

> Below are listed a variety of ways that one person may feel or behave in relation to another person. We are interested in how you view the ideal psychotherapist in action. For this task assume that you have had several sessions with your therapist. You feel that this therapist is ideal--interacts with you in every way exactly as you desire. In other words, insofar as you are concerned he is a perfect, ideal therapist. We would like you to answer the questions below with thie set in mind. That is, answer all the questions according to how you feel your ideal therapist would behave.

2) Gilbert Self-Interview. The Gilbert Self-interview is a special diagnostic procedure developed as part of the University of Illinois Counseling Center research project (Hunt et al., 1957, 1958a, 1958b, 1959). It was designed as a standardized interview procedure wherein the prospective client responds to type-written 3 x 5 inch index cards requesting that the client describe himself aloud regarding ten distinct potential problem areas. The client responds by talking into a tape-recorder, in a room by himself. For the present study Ss were requested to restrict each of their 10 vocal responses to approximately four minutes.

Both the UNG and UCS Ss performed the self-interview task individually in one of several therapy offices in the University of Iowa Counseling Service. The written instructions handed to each S to read before he performed the self-interview were as follows:

> In order to understand and help you, and for research which will help others, it is necessary to know as much as you can tell us about your real attitudes and feelings, both good and bad, and your problems, if any, in all important areas of your life. To help you do this we have listed on some cards those aspects of living which seem to be important for most people. One aspect or area is typed on the back of each of these 10 cards.
>
> When you are told to begin this test, the examiner will turn on the recording machine and leave the room. You will carefully turn over the first card and read aloud the number of the card and the typed description of the area of your life you are to talk about first. As soon as you have read this aloud begin at once to describe all your real attitudes and feelings, both good and bad, and your problems, if any, about this part of your life. Just state your ideas as they come to you. Don't worry about organizing the ideas or about your grammar. Just talk naturally. Pause whenever you want to but never turn off the recording maching. It costs very little to run and we want a record of your natural pauses too.
>
> You should spend an average of up to about four minutes on each card. You may need less time for some cards and more for others. This is alright.
>
> As soon as you are finished with the first card lay it down on the right side of the machine. Pick up the next one, turn it over, read aloud its

> number and the description on it and then tell about attitudes, feelings and problems as you did for the first card. Do this for each of the cards in turn. Do not look ahead. Speak in a fairly loud and distinct voice so you will make a good recording. What you say will of course be kept confidential. Remember, never turn off the recording machine.
>
> If, while you are saying something about the area on one of the later cards that reminds you of something you feel you should have said earlier, just go ahead and say that it does and what it was you remembered, and then return to the subject you had been telling about. If you have any questions ask the examiner.

For the UNG Ss the following paragraph was inserted at the beginning of the above instructions:

> We are trying to learn more about the process of counseling. We would like you to read the following instructions and do what they direct as sincerely as possible. For this task, we are asking you to assume that you now feel a need for personal counseling, and have come to the University Counseling Service for assistance. Of course, the information you give us remains entirely confidential and will be used for research purposes only.

For both the UNG and UCS Ss the cards contained the following problem areas in this same order: 1) Your educational and vocational goals at the University and in life, and how you feel you are progressing. 2) Your family, including your mother and father, and your wife if you are married. 3) How well you get along generally with people of both sexes. 4) Your emotional and physical relationships with the opposite sex. 5) Your financial situation. 6) Your ethical, moral, and religious views. 7) Your abilities, aptitudes, and skills. 8) The most unfavorable and undesirable aspects of your own personality and yourself generally. 9) The most favorable and desirable aspects of your own personality and yourself generally. 10) Any aspect of your life which you consider important and which has not already been covered.

Two examiners administered the self-interviews to the Ss. A male examiner administerd them for all the UNG Ss, while a female receptionist at the Counseling Service administered them to all the UCS Ss. The mean length of time the 68 UCS Ss talked for the entire self-interview was 24.8 minutes, while the mean for the 88 UNG Ss was 23.4 minutes. Later analyses indicate that these values are not statistically different.

Experiencing Ratings. The primary purpose of the self-interviews was to provide a sample of self-verbalization from which Experiencing Scale (Klein, Mathieu, & Kiesler, 1969) ratings could be obtained. To obtain the raw tape-recorded data for the EXP ratings, the arbitrary decision was made to extract two 5-minute samples from each of the total 156 UNG and UCS Ss' Gilbert Ss' Self-Interviews, yielding a total of 312 5-minute segments. This decision was made since 1) the total time of the 156 distinct self-interviews (the total amount of the time each S talked about himself) varied markedly, and 2) since the absolute values of EXP ratings are positively related to sample size (Kiesler, Mathieu, & Klein, 1967) with longer samples tending to receive higher EXP ratings, it was necessary to standardize segment size.

As a result two 5-minute tape segments were extracted randomly from earlier and later portions of each self-interview. To control for content area on the various 10 self-interview cards, it was arbitrarily decided that the early sample would be restricted to the S's responses to cards 2, 3, and 4 (family, both sexes, opposite sex), the later sample from cards 6, 8, and 9 (moral views, unfavorable and favorable aspects of self). The time of each S's response for each of the 10 questions had been previously tabulated, so that the cumulative amount of time of each S's responses to questions 2-3-4 as well as 6-8-9 respectively has been extablished. The segmenter then randomly, by table of random numbers, entered into the early and late time-blocks for each S, and began his recording of the particular 5-minute segment at the indicated random time-point within each block. The segmenter transcribed each 5-minute extract on separate 3-inch tape spools.

Hence, the basic raw self-interview data used for the EXP ratings consisted of 312 separate 3-inch tape spools, including one early and one late 5-minute self-interview segment for each of the 68 UCS and 88 UNG Ss. These 312 spools were edited for identifying information, coded, and arranged in a standard random order (by a table of random numbers) into boxes of 12 spools each. The EXP raters listened to the tapes (in one research room, using headphones; sometimes alone, often with other raters present) in the same random order and make an EXP rating for each of the 312 5-minute segments.

The EXP raters were 4 paid undergraduate student volunteers from Emory and Georgia State Universities, 3 male and 1 female. Previous studies have shown that clinically naive judges attain the same level of reliability and statistically equivalent EXP ratings as experienced clinicians (Kiesler, 1969). The four judges for the present study were trained in a group with eight other similar judges (used for other projects), using the standardized training procedure outlined in the Experiencing Scale Manual (Klein et al., 1969). The training procedure involves listening to 90 training segments (from 2 to 16 minutes in length) and intermittently comparing the trainees' ratings with the manual's criterion ratings and respective rating rationales. The group was permitted to discuss the discrepancies among their ratings in the group sessions, but the trainer did not participate in these discussions. The training period required five 3-hour training sessions on a once-a-week basis.

Upon completion of the training sessions, the four judges for the present study independently listened to and rated for level of EXP the 312 5-minute self-interview segments. The mean of the four judges' ratings for each of the segments constitue the raw EXP scores used in subsequent analyses.

The judges routinely made two EXP ratings for each segment. A modal EXP rating characterizes the overall, most-frequent, or average level of EXP in the given segment. A peak rating is given to the highest EXP level that is reached only momentarily in the given segment. Because the mode and peak EXP ratings intercorrelate very highly (in the low .90s), and since the mode and peak ratings for the present 312 segments intercorrelated with a range of .60 to .80 for the UNG and UCS male and female samples, only the modal EXP ratings will be used in subsequent analyses. The modal rating also represents the more theoretically congruent measure (Rogers et al., 1967). The Ebel intraclass (r_{kk}) reliabilities (Guilford, 1954) of the means of the four judges' EXP ratings for the 312 segments were .58 for the modes and .75 for the peaks. These values are borderline satisfactory, and are not representative of previous interrater reliabilities obtained (between .80 and .90). The explanation for this seems to lie with the restricted range of EXP scores obtained for the present self-interviews, in contrast to previous studies which used live psychotherapy interviews. The mean EXP modal rating was 2.28 (SD = .310) for the 88 UNG Ss, and 2.32 (SD = .365) for the 68 UCS Ss.

Summary. As a result of the data collection procedures, the following scores were available for the 156 Ss of the

study: 1) Bendig E and EI scores which were used to classify Ss in one of the four Eysenck personality groups, 2) Marlowe-Crowne SD, Couch-Keniston RA, and Barrett-Lennard RI (R + E + C) scores, 3) Sex and modified Hollingshead and Redlich SE scores, and 4) EXP modal ratings (mean of 4 raters) on 156 early and 156 late Gilbert Self-Interview segments.

Results

This section will present two sets of analyses. First, it will compare the Experiencing Scale scores for the four Eysenck personality groups within the normal UNG sample only. Secondly, it will consider the Experiencing Scale scores of two of Eysenck's personality groups in both the UNG and UCS samples--namely, UNG obsessives and UNG hysterics vs UCS obsessives and UCS hysterics. Both sets of analyses will consider further the relationship of the ancillary demographic and questionnaire measures to the Eysenck's personality groups.

1) Eysenck's Four Personality Groups in the UNG Sample. The 2 x 2 x 2 factorial analyses of variance in this section represent males vs females by Hi-Lo Emotionality (E) by Hi-Lo Extraversion-Introversion (EI). In other words they look at Eysenck's four personality groups (normal hysterics, normal obsessives, normal extraverts, normal introverts) among the male and female undergraduate (UNG) Ss only. The designs in this section have equal ns (n = 10) in each of the 8 cells, a total N of 80 UNG Ss. Two Ss were randomly deleted from the 12 available for male and female UNG hysterics and UNG obsessive groups in order to match the ns available for the normal extravert and normal introvert groups.

Experiencing (EXP) Scale Analysis

The means of the four judges' modal EXP ratings for the Gilbert Self-Interviews were analysed in a 2 x 2 x 2 factorial analysis of variance for the male vs female, Hi vs Lo E, and Hi vs Lo EI groups. The design has equal ns (n = 10) in each of the 8 cells, a total of 80 Ss. For each of the Ss the modal EXP score used is the average level (mean) of EXP for the particular S for his two 5-minute samples, one extracted from an early and the other from a late portion of his Gilbert Self-Interview recording.

Table 11 presents the summary table for the 2 x 2 x 2 factorial analysis of variance of the EXP scores for the 40 male and 40 female Ss, by Eysenck's HH, HL, LH, and LL personality groups. The only statistically significant effect was the 3 factor interaction ($p<.05$). Figure 7 depicts the EXP scores for the eight personality groups. First, it is evident that the two extreme Eysenck groups, HH-hysterics and LL-introverts, have their EXP scores reversed in the male in contrast to the female samples. For males HL-obsessives show the highest level of EXP with the LL-introverts Ss lowest. In contrast, LL-introvert females show the highest EXP level with the HL-obsessive females lowest.

Table 11

Summary Table of the 2 x 2 x 2 Factorial Analysis of Variance of the EXP Scale Scores for 40 Male vs 40 Female Ss, by Hi-Lo Emotionality (E), by Hi-Lo Extraversion-Introversion (EI) Eysenck personality groups (n = 10 in each of 8 cells).

Source of Variation	Sum of Squares	df	Mean Squares	F Ratio	P level
Male-Female	.12	1	.12	1.33	
Hi-Lo E	.17	1	.17	1.89	
Hi-Lo EI	.01	1	.01	<1	
M-F x HL Em	.32	1	.32	3.56	<.10
M-F x HL EI	.02	1	.02	<1	
HL Em x HL EI	.01	1	.01	<1	
M-F x HL Em x LH EI	.46	1	.46	5.11	<.05
Error	6.50	72	.09		
Total	7.61	79			

Eysenck's intermediate groups (HH-hysterics and LH-extraverts) are indistinguishable for the females, while for males the HH-hysterics score higher in EXP than the LH-extraverts. Further, it is apparent there is a wider range of EXP scores present for the four groups of male normals than for the female normals.

The Sex by Hi-Lo E (emotionality or neuroticism) interaction tended to significance ($p < .10$), and is depicted in Figure 8. The figure shows a clear crossover interaction with Hi E Ss (regardless of EI score) showing a higher level of EXP than the Lo E for males. For females Lo Es showed a higher level of EXP than the Hi E Ss. The Lo E male Ss are sharply discrepant from the other three personality groups.

Hence, analysis of the EXP scores for the four male and four female UNG personality groups indicate that 1) for males obsessives showed the highest level of EXP, the introverts the lowest--with hysterics having an edge over the extraverts in between the HLs and LLs, 2) for females the pattern was reversed, with obsessives attaining the lowest EXP scores, introverts the highest level, and the hysterics and extraverts indistinguishable in between, and 3) there is a tendency ($p < .10$) for the Emotionality factor of itself to be related to EXP in opposite ways for the males and females, with the Hi Es scoring higher in EXP among the males, Lo Es among the females.

Ancillary Demographic and Questionnaire Measures

Additional 2 x 2 x 2 (M-F x H-L E x H-L EI) factorial analyses of variance were calculated for the following dependent variable scores: Hollingshead-Redlich socioeconomic (SE) level, Marlowe-Crowne Social Desirability (SD), Couch-Keniston Response Acquiescence (RA), Barrett-Lennard's Relationship Inventory (RI) scores on "ideal therapist," and the total time S talked (Talk-time) during the Gilbert Self-Interview. Table 12 presents the analysis of variance summary tables for the five separate 2 x 2 x 2 factorial analyses of variance (n = 10 per cell, a total of 80 Ss).

Hollingshead-Redlich Socioeconomic (SE) Status. From Table 12 it is apparent that only one ANOVA effect is statistically significant for the SE scores. The main effect for sex is significant at the .05 level, indicating that males of the study come from significantly lower (mean = 10.1) socioeconomic families than females (mean = 8.4),

Figure 7

Significant 3 Factor Interaction (Males-Females x Hi-Lo Emotionality x Hi-Lo Extraversion-Introversion) for the EXP Scores (n = 10 in each of the 8 groups).

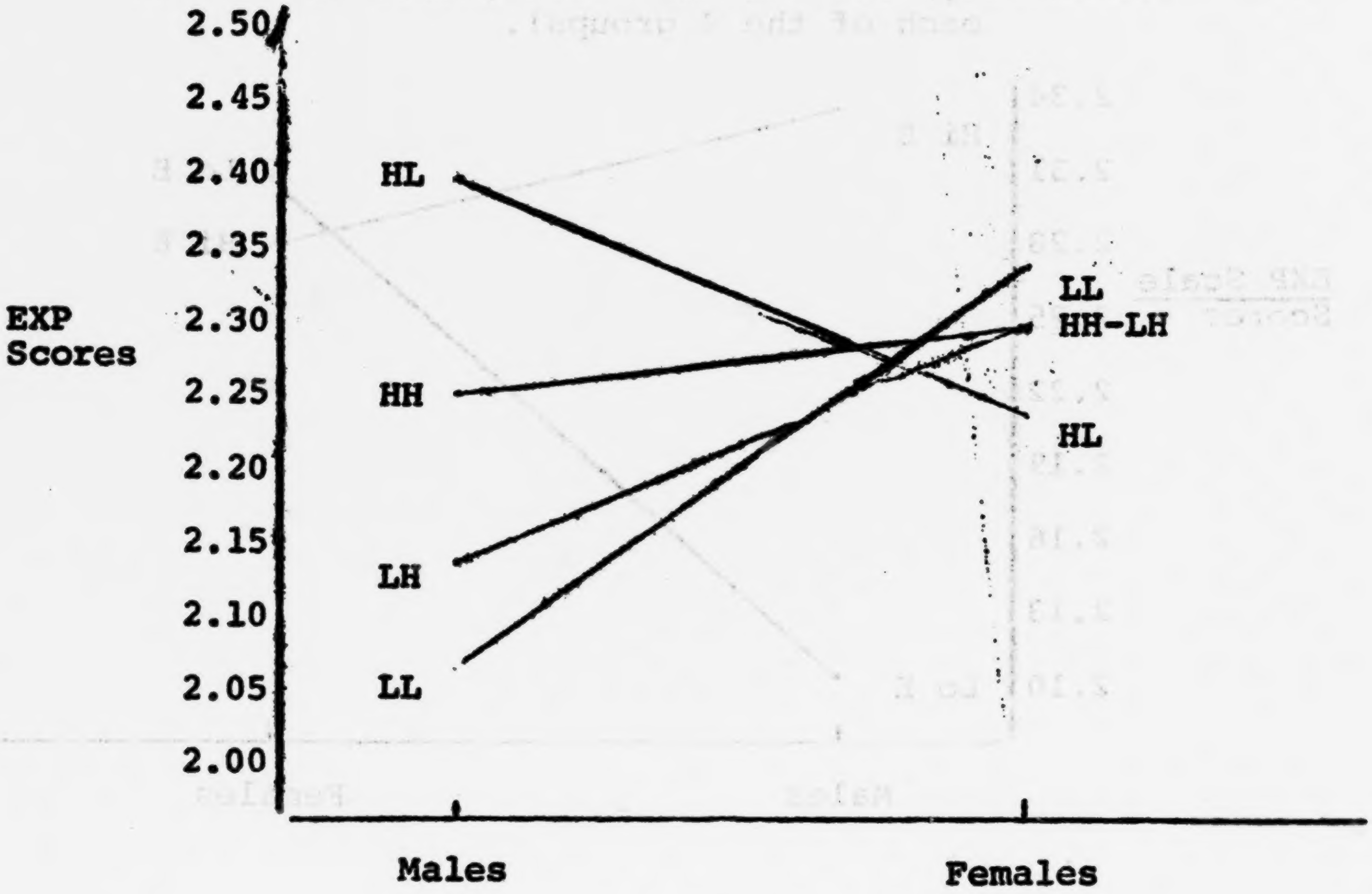


Figure 8

Significant ($p < .10$) 2 Factor Interaction (Males-Females x Hi-Lo Emotionality) for the EXP Scale Scores (n = 20 in each of the 4 groups).

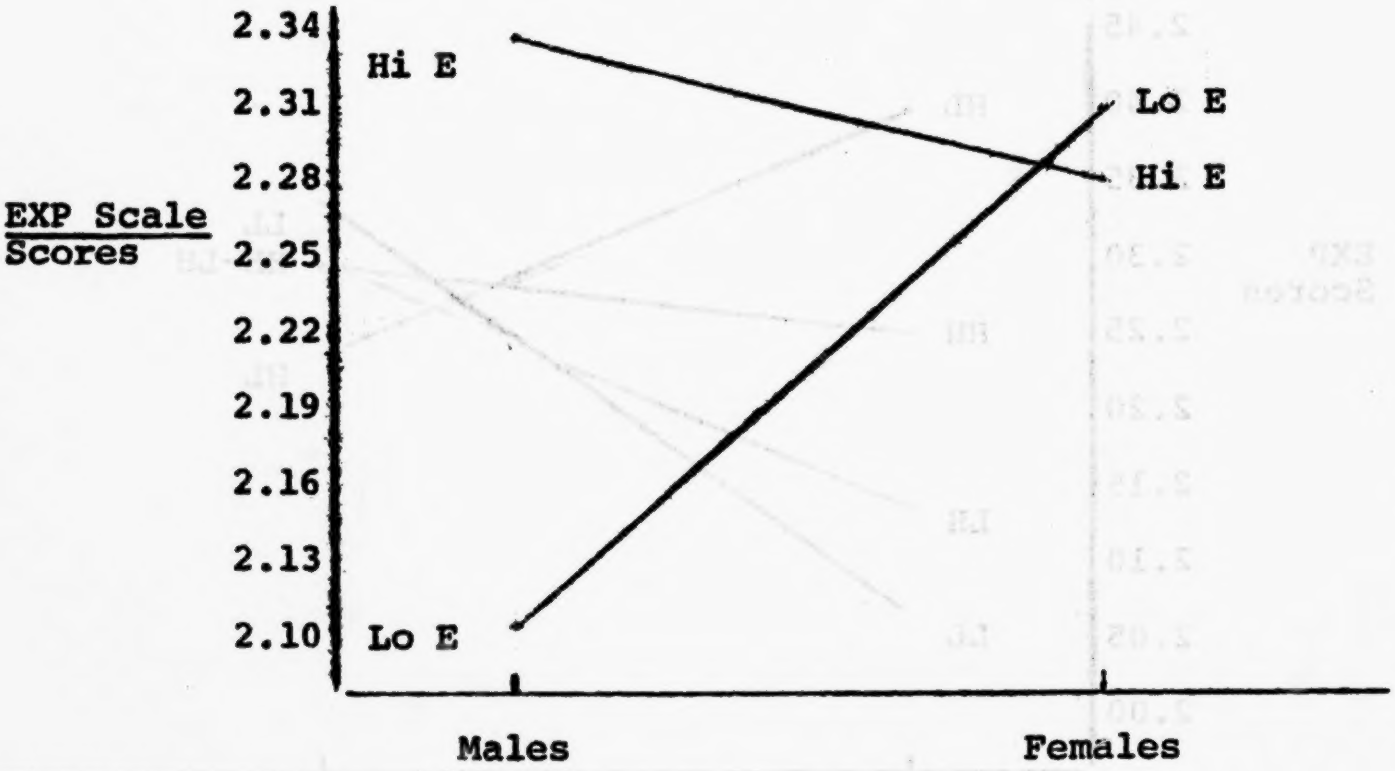


Table 12

Summary Tables for 2 x 2 x 2 (Males-Females x Hi-Lo Emotionality x Hi-Lo Extraversion-Introversion) Factorial Analyses of Variance for Socioeconomic (SE) Status, Social Desirability (SD), Response Acquiescence (RA), Relationships Inventory (RI) Talk-Time Scores.

		Mean Squares				
Sources of Deviation	df	SE	SD	RA	RI	Talk-Time
Male-Female	1	59.5	.4	270.1	505.0	1,097,929.
Hi-Lo Em	1	2.8	627.2	1,757.8	3,740.1	45,792
Hi-Lo EI	1	0.0	0.0	877.8	775.0	426,028
M-F x HL Em	1	19.0	14.5	21.0	475.4	211,768
M-F x HL EI	1	.2	51.3	23.2	[illegible]2.1	52,428
HL Em x HL EI	1	7.9	22.1	90.3	465.6	52,736
M-F x HL Em x HL EI	1	28.5	92.8	450.5	1,097.1	631,436
Error	72	11.15	24.12	69.41	676.77	235,176
Total	79					

Sources of Deviation	SE	SD	RA	RI	Talk-Time
Male-Female	5.34	<1	3.89	<1	4.67
Hi-Lo Em	<1	26.00	25.32	5.53	<1
Hi-Lo EI	<1	<1	12.65	1.14	1.81
MF x HL Em	1.70	<1	<1	<1	<1
MF x HL EI	<1	2.13	<1	<1	<1
HL Em x HL EI	<1	<1	1.30	<1	<1
MF x HL Em x HL EI	2.56	3.85	6.49	1.62	2.68

regardless, of Eysenck personality scores.

Marlowe-Crowne Social Desirability (SD). Table 12 shows that only one effect is statistically significant for the SD scores, the main effect for the Emotionality factor ($p<.01$). The data indicate that low emotionality Ss attain higher social desirability scores (mean = 16.0) than Hi E Ss (mean = 10.4). Low emotional or anxious Ss tend to place higher importance on the expectations of others (the social norm) regarding their behavior than do high anxious individuals.

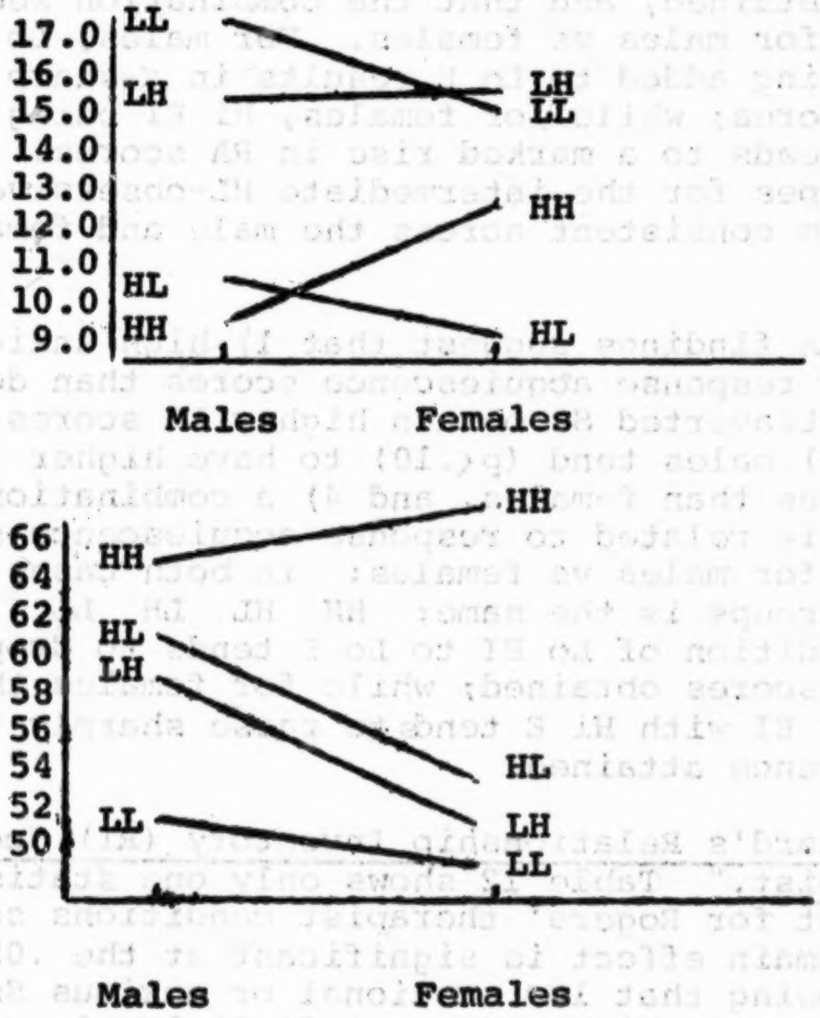
There was a tendency ($p<.10$) for the three factor interaction to be statistically significant, and it is depicted in Figure 9. The figure shows again the relationship of Emotionality to the SD scores, with low E Ss, males and females, clearly higher than the high E Ss, with no overlap of the mean scores. Additionally, the figure shows a crossover interaction when the Extraversion-Introversion factor is included. For both Lo and Hi E Ss, the Lo EI (introverted) Ss are higher in social desirability. This effect is more dramatic for the Hi E Ss, where among males HL-obsessives have higher SD scores than HH-hysterics, while for females HH-hysterics show greater SD than HL-obsessives.

Thus, for the SD variable the findings indicate that 1) low emotional or low anxious Ss are more concerned about the social desirability aspects of questionnaire responses than are high emotional Ss, regardless of sex or of extraversion-introversion score, and 2) among the high anxious Ss particularly there is a clearcut tendency for obsessive males and hysteric females to receive higher SD scores than their respective counterparts.

Couch-Keniston Response Acquiescence (RA). It's clear from Table 12 that both personality factors by themselves, and in interaction with each other and the sex factor, are significantly related to response acquiescence scores. The main effect for Emotionality is significant at the .01 level, and reveals that Hi E Ss attain higher (mean = 62.2) RA scores than do Lo Es (mean = 52.8). Likewise, the main effect for Extraversion-Introversion is statistically significant ($p<.01$) indicating that Hi EI (extraverted) Ss receive higher (mean = 60.8) acquiesence scores than do Lo EI (introverted) Ss. Further, there is a tendency ($p<.10$) for the sex main effect to be statistically significant, showing that males obtain higher (mean = 59.4) RA scores than females (mean= 55.7).

Figure 9

Significant 3 Factor Interactions (Male-Female x Hi-Lo Emotionality x Hi-Lo Extraversion-Introversion) for the SD (p<.10), and RA (p<.05) Scores. (n = 10 in each of the 8 groups).*



*** HH = Hi E, Hi EI (hysterics)**
HL = Hi E, Lo EI (obsessives)
LH = Lo E, Hi EI (introverts)
LL = Lo E, Lo EI (extraverts)

The three factor interaction is the only significant ($p<.05$) interaction effect, and is depicted in Figure 9. The figure shows that the ranking of the four personality groups is identical for male and female Ss. HH-hysterics have the highest RA scores, LL-introverts the lowest, with HL- obsessives and LH-extraverts in between. Further, it seems that a combination of E and EI factors is related to the level of RA obtained, and that the combination seems to work differently for males vs females. For males, Lo EI (introversion) being added to Lo E results in a sharp drop in the RA scores; while for females, Hi EI being combined with Hi E leads to a marked rise in RA scores. In contrast, the slopes for the intermediate HL-obsessives and LH-extraverts seem consistent across the male and female samples.

Hence, the RA findings suggest that 1) high anxious Ss receive higher response acquiescence scores than do low anxious Ss, 2) extraverted Ss obtain higher RA scores than introverted Ss, 3) males tend ($p<.10$) to have higher acquiescence scores than females, and 4) a combination of E and EI factors is related to response acquiescence somewhat differently for males vs females: in both cases the ordering of the groups is the same: HH HL LH LL. But for males, the addition of Lo EI to Lo E tends to drop considerably the RA scores obtained; while for females the combination of Hi EI with Hi E tends to raise sharply the level of acquiescence attained.

Barrett-Lennard's Relationship Inventory (RI) Scores for "Ideal Therapist." Table 12 shows only one statistically significant effect for Rogers' therapist conditions score. The Emotionality main effect is significant at the .05 level, with the data showing that low emotional or anxious Ss attribute significantly higher (mean = 88.6) levels of relationship attitudes to their ideal therapist than do high emotional Ss (mean = 74.9). In other words, high anxious Ss describe their fantasized ideal therapist as having less of the therapist attitudes Rogers considers therapeutically successful than do low anxious Ss.

Total Amount of Time S Talked (Talk-Time) During the Gilbert Self-Interview. The final correlary analysis for the 80 undergraduate Ss involves the measure of the total amount of time, in seconds, each S talked in response to the Gilbert Self-Interview situation. Table 12 indicates that only one ANOVA effect is statistically significant for the Talk-time scores. The Sex main effect is significant at the .05 level, with the data showing that males, regardless of personality grouping, talked significantly longer (mean = 25.33 minutes) than did females (mean = 21.43). In other words, males were more productive verbally in the self-interview situation than were females.

2) Eysenck's Two Personality Groups in the UNG vs UCS Samples. The 2 x 2 x 2 analyses of variance of the present section differ from those of the previous in that the psychoneurotic (UCS) Ss are included, while the two normal low emotionality (neuroticism) groups, normal extraverts and normal introverts, of the previous section are deleted. The fact that low emotionality Ss are eliminated means that all the Ss in this section's analyses are high anxious Ss (having high Bendig E scores). Hence the 2 x 2 x 2 factorial analyses in this section represent UNG vs UCS by male vs female by hysteric (HiE-HiEI) vs obsessive (HiE-LoEI) Ss. It compares UCS hysterics and UCS obsessives with UNG hysterics and UNG obsessives for males and females. The designs in this section have unequal but proportional ns for the UCS and UNG samples, as follows:

		UCS	UNG
Males:	HiE-HiEI	n = 17	n = 12
	HiE-LoEI	n = 17	n = 12
Females:	HiE-HiEI	n = 17	n = 12
	HiE-LoEI	n = 17	n = 12
		n = 68	n = 48

The 17 Ss per cell for the UCS Ss were selected for each of the four groups from a larger pool by table of random numbers when the total available ns were greater than 17. The 12 Ss in each of the UNG groups represented the total number of Ss available in that sample.

Experiencing (EXP) Scale Analysis

The means of the four judges' modal EXP ratings for the Gilbert Self-Interviews were analysed in a 2 x 2 x 2 factorial analysis of variance (Edwards, 1962) for the UCS vs UNG by male vs female by obsessive vs hysteric Ss. For each of the Ss the modal EXP score used is the average (mean) level of EXP for the particular S for his two 5-minute samples, one extracted from an early and the other from a late portion of his Gilbert Self-Interview recording.

Table 13 presents the summary table for the 2 x 2 x 2 analysis of the EXP scores for the 68 UCS vs 48 UNG Ss. None of the main effect differences in EXP scores was statistically significant. There were no differences in self-interview EXP scores for the UCS vs UNG samples as a whole (means were 2.32 and 2.34 respectively), and for the hysteric vs obsessive personality groups as a whole (means were 2.35 vs 2.31 respectively). The male-female main effect showed a trend for significance ($p < .10$, df = 1,108), with female Ss in both the UCS and UNG samples manifesting a higher level of EXP (mean = 2.38) than males (mean = 2.27).

The sole statistically significant interaction term was the 3 factor interaction of UCS-UNG x M-F x HiHi-HiLo ($p < .05$). Figure 10 presents the EXP scores for this three factor interaction. It is apparent from the figure that one of the personality groups is out of phase with the others. The UCS male HL-obsessives show a markedly lower level of EXP than the other groups. There is also a tendency for the UCS personality groups (with the exception of the male HLs) to attain higher levels of EXP than the UNG Ss. The significant interaction seems to be the result primarily of the male Ss. For males the HH-hysterics attain a higher level of EXP than the HL-obsessives in the UNS group, while the obsessives attain a higher level of EXP in the UNG group. In other words, UCS-hysterics talk more meaningfully about themselves in a self-interview situation than UCS-obsessives, while UNG obsessives talk at a deeper level of self-expression than UNG hysterics.

Hence, the primary result for the EXP scores is that the factor of psychoneurotic status (defined as coming to a counseling service for help with personal problems) has an interactive effect for obsessive vs hysteric personalities on the level of EXP shown in a self-interview situation. Psychoneurotic hysteric and normal obsessive males show higher levels of self-revelation in their speech than their respective normal male counterparts. Female Ss do not show this crossover pattern. In addition, there is a tendency ($p < .10$) for the female Ss generally to manifest deeper levels of self-exploration than the males.

Ancillary Demographic and Questionnaire Measures

Additional 2 x 2 x 2 (UCS-UNG x M-F x HH-HL) factorial analyses of variance were calculated on the following dependent variables scores: socioeconomic level (SE), Marlowe-Crowne Social Desirability (SD), Couch-Keniston Response Acquiescence (RA), Barrett-Lennard's Relationship Inventory

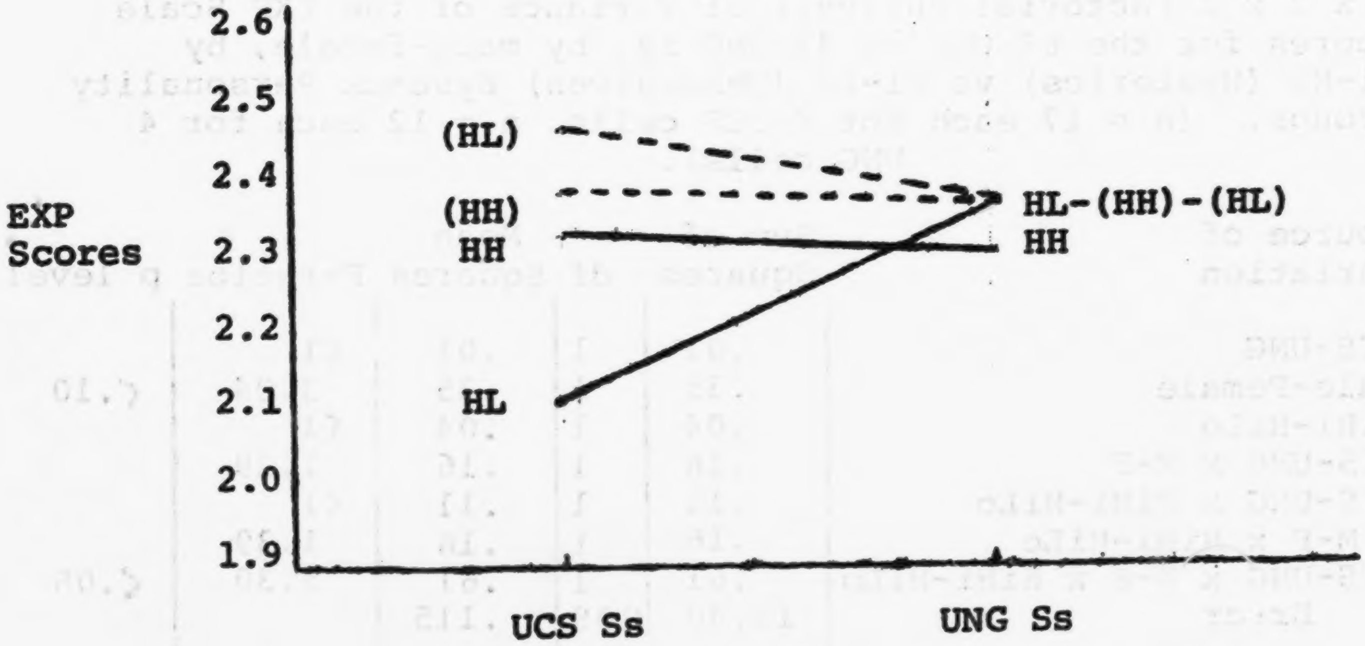
Table 13

2 x 2 x 2 Factorial Analysis of Variance of the EXP Scale Scores for the 68 UCS vs 48 UNG Ss, by male-female, by Hi-Hi (Hysterics) vs Hi-Lo (Obsessives) Eysenck Personality Groups. (n = 17 each for 4 UCS cells, n = 12 each for 4 UNG cells).

Source of Variation	Sum of Squares	df	Mean Squares	F-ratios	p level
UCS-UNG	.01	1	.01	<1	
Male-Female	.35	1	.35	3.04	<.10
HiHi-HiLo	.04	1	.04	<1	
UCS-UNG x M-F	.16	1	.16	1.39	
UCS-UNG x HiHi-HiLo	.11	1	.11	<1	
M-F x HiHi-HiLo	.16	1	.16	1.39	
UCS-UNG x M-F x HiHi-HiLo	.61	1	.61	5.30	<.05
Error	12.40	108	.115		
Total	13.84	115			

Figure 10

Significant ($p < .05$) 3 Factor Interaction (UCS-UNG x M-F x HH-HL Personality Groups) for the EXP Scale Scores (n = 17 each in the 4 UCS groups, 12 each in the 4 UNG group)*



* HH = Hi E, Hi EI (hysterics)
HL = Hi E, Lo EI (obsessives)

———— Males
------- Females

(RI), and the total time an S talked in the self-interview (Talk-time). Table 14 presents the analysis of variance summary tables for the five separate 2 x 2 x 2 factorial analyses of variance.

Socioeconomic (SE) Status. Becuase there were several cases with missing SE data, analysis could not be performed for the same size cells as for the other variables. Instead, a 2 x 2 x 2 factorial analysis of variance was performed for the SE scores with n = 10 in each of the 8 cells (in contrast to four 17s and four 12s). Table 14 shows that none of the main or interaction effects is statistically significant. That is, the psychoneurotic vs normal, male vs female, or HH-hysteric vs HL-obsessive variables were unrelated to socioeconomic level of Ss in the present samples. One main effect, UCS-UNG tended ($p < .10$) to indicate that the undergraduates came from homes of lower (mean = 9.42) socioeconomic status than the counseling service psychoneurotics (mean = 7.98), as indicated by the modified Hollingshead-Redlich index.

Marlowe-Crowne Social Desirability (SD). Table 14 shows that only one ANOVA effect is statistically significant for the SD scores, the male-female main effect ($p < .05$). Female Ss in both the UCS and UNG samples received significantly higher social desirability scores (mean = 12.1) than males (mean = 9.6). This suggests that females, whether psychoneurotic or normal, place a higher importance on the expectations of other people (the social norm) regarding their behavior than do males of either population.

The 3 factor interaction tends ($p < .10$) to be significant and is depicted in Figure 11. The figure shows again the main effect of sex in that the means of all four female personality groups are higher than those of the respective four male groups. It further shows that the obsessive-hysteric relationship to social desirability is reversed for the sexes. For females the HH-hysterics have higher SD scores in both the UNG and UCS groups, while for males the HL-obsessives have higher SD scores in both populations.

Hence, the findings for the SD scores indicate that 1) females, whether psychoneurotic or normal, attain higher social desirability scores than their male counterparts, and 2) among females hysterics place more emphasis on social desirability considerations (both clients and normals), while among males obsessives attain higher SD scores than the client and normal hysterics.

Table 14

Summary Tables for 2 x 2 x 2 (UCS-UNG x M-F x HiHi Hysteric-HiLo Obsessive) factorial Analysis of Variance for SE Status[1], SD, RA, RI, and talk-time Scores.

Sources of Deviation:		Mean Squares				
	df	SE[1]	SD	RA	RI	Talk-Time
UCS-UNG	1	42.0	5.4	1,951.2	912.9	73,380.3
Male-Female	1	12.8	181.2	8.3	7,829.4	365.8
HiHi-HiLo	1	3.2	1.9	295.0	3,675.9	13,297.9
UCS-UNG x M-F	1	.1	15.7	63.1	47.0	376,251.7
UCS-UNG x HiHi-HiLo	1	1.3	26.4	105.3	889.6	1,848,002.1
M-F x HiHi-HiLo	1	.2	59.5	5.4	355.3	229,887.1
UCS-UNG x M-F x HiHi-HiLo	1	2.8	101.6	578.2	1,892.4	2,612,059.3
Error	108	12.26	28.12	119.6	812.5	330,432.7
Total	115					

Sources of Deviation:	F Ratios (df = 1,108)				
	SE	SD	RA	RI	Talk-Time
UCS-UNG	3.43‡	<1	16.31**	1.12	<1
Male-Female	1.04	6.44*	<1	9.64**	<1
HiHi-Hi-Lo	<1	<1	2.47	4.52*	<1
UCS-UNG x M-F	<1	<1	<1	<1	1.14
UCS-UNG x HiHi-HiLo	<1	<1	<1	1.10	5.59
M-F x HiHi-HiLo	<1	2.12	<1	<1	<1
UCS-UNG x M-F x HiHi-HiLo	<1	3.61‡	4.83*	2.33	7.90**

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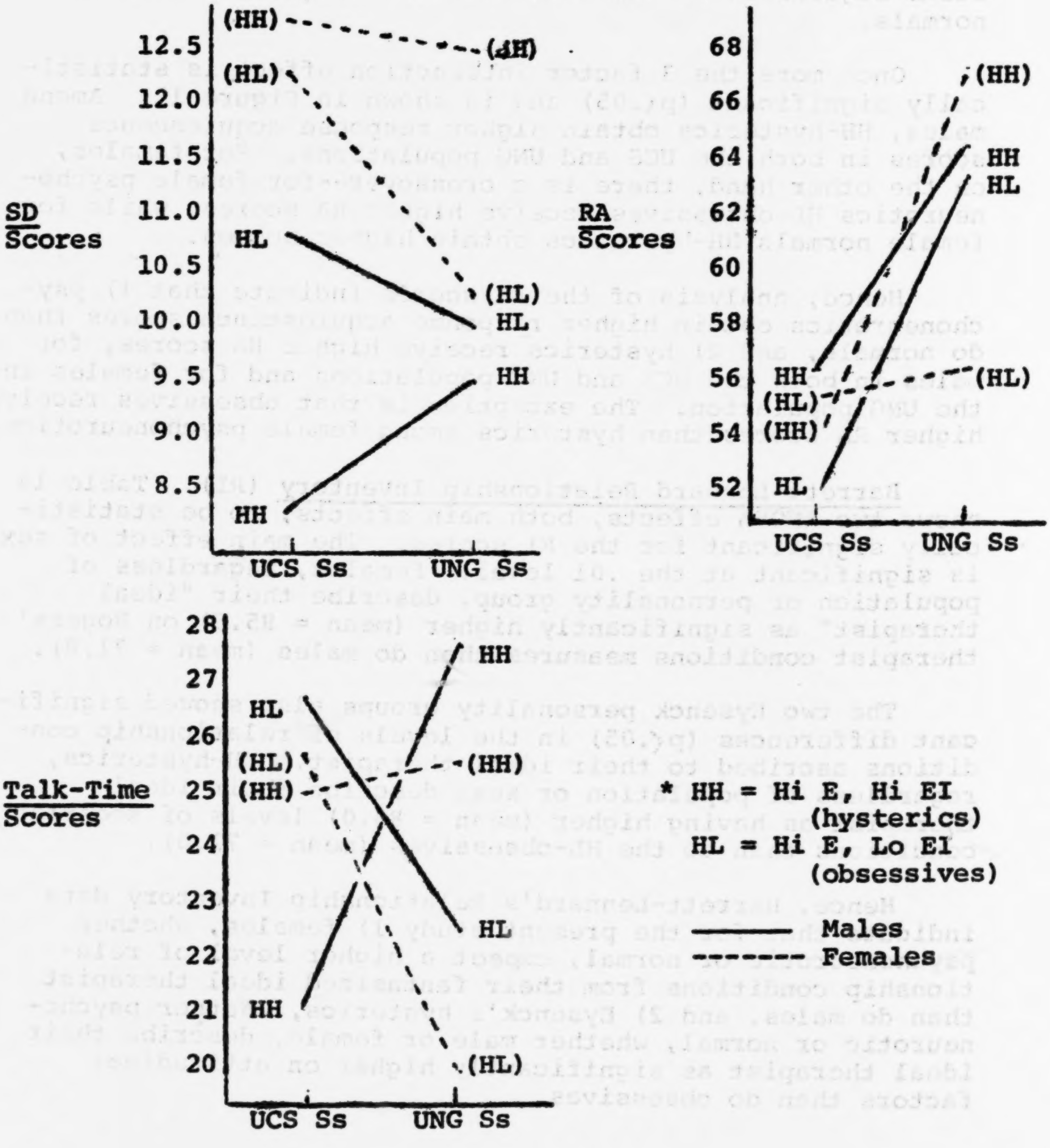
[1] Because of missing data, the SE status analyses are based upon n = 10 in each of the 8 cells of the design, (df = 1, 72).

** F significant at .01 level
* F significant at .05 level
‡ F significant at .10 level

Figure 11

Significant 3 factor Interactions (UCS-UNG x M-F x HH-HL Eysenck Groups) for the SD (p<.10), RA (p<.05), and Talk-Time (p<.01) Scores. (n = 17 each in the 4 UCS groups, n = 12 each in the 4 UNG groups).*



* HH = Hi E, Hi EI (hysterics)
HL = Hi E, Lo EI (obsessives)

Couch-Keniston Response Acquiescence (RA). Table 14 reveals two statistically significant effects for the RA scores. The UCS-UNG main effect is significant at the .01 level, with the clients attaining higher (mean = 63.1) RA scores than normals (mean = 54.1). Psychoneurotic Ss (both male and female) tend to respond "yes" to questionnaire items regardless of item-content more frequently than do normals.

Once more the 3 factor interaction effect is statistically significant ($p < .05$) and is shown in Figure 11. Among males, HH-hysterics obtain higher response acquiescence scores in both the UCS and UNG populations. For females, on the other hand, there is a crossover--for female psychoneurotics HL-obsessives receive higher RA scores, while for female normals HH-hysterics obtain higher scores.

Hence, analysis of the RA scores indicate that 1) psychoneurotics obtain higher response acquiescence scores than do normals, and 2) hysterics receive higher RA scores, for males in both the UCS and UNG populations and for females in the UNG population. The exception is that obsessives receive higher RA scores than hysterics among female psychoneurotics.

Barrett-Lennard Relationship Inventory (RI). Table 14 shows two ANOVA effects, both main effects, to be statistically significant for the RI scores. The main effect of sex is significant at the .01 level. Females, regardless of population or personality group, describe their "ideal therapist" as significantly higher (mean = 85.6) on Rogers' therapist conditions measures than do males (mean = 71.8).

The two Eysenck personality groups also showed significant differences ($p < .05$) in the levels of relationship conditions ascribed to their ideal therapist. HH-hysterics, regardless of population or sex, describe their ideal therapist as having higher (mean = 83.0) levels of Rogerian conditions than do the HL-obsessives (mean = 71.8).

Hence, Barrett-Lennard's Relationship Inventory data indicate that for the present study 1) females, whether psychoneurotic or normal, expect a higher level of relationship conditions from their fantasized ideal therapist than do males, and 2) Eysenck's hysterics, whether psychoneurotic or normal, whether male or female, describe their ideal therapist as significantly higher on attitudinal factors than do obsessives.

Total Amount of Time S Talked (Talk-Time) During the Gilbert Self-Interview. The final correlary analysis for the present section involves the measure of the total amount of time in seconds, each S talked in response to the self-interview condition. Table 14 indicates that none of the main effects for the Talk-Time scores is statistically significant, while one of the 2 factor interactions as well as the 3 factor interaction are.

The significant 2 factor interaction ($p < .05$) between the UCS-UNG and HH-HL variables is depicted in Figure 12 (seconds are converted to minutes for the figure). The figure shows a clearcut crossover pattern with HL-obsessive clients talking significantly more than hysteric clients; while for normals the pattern is reversed, with HH-hysterics talking more than the obsessives.

The significant ($p < .01$) 3 factor interaction is shown in Figure 11. Again the above UCS-UNG by HH-HL crossover pattern is evident for both males and females. However, the pattern seems much less clearcut for females, primarily in that female psychoneurotic hysterics and obsessives are virtually indistinguishable.

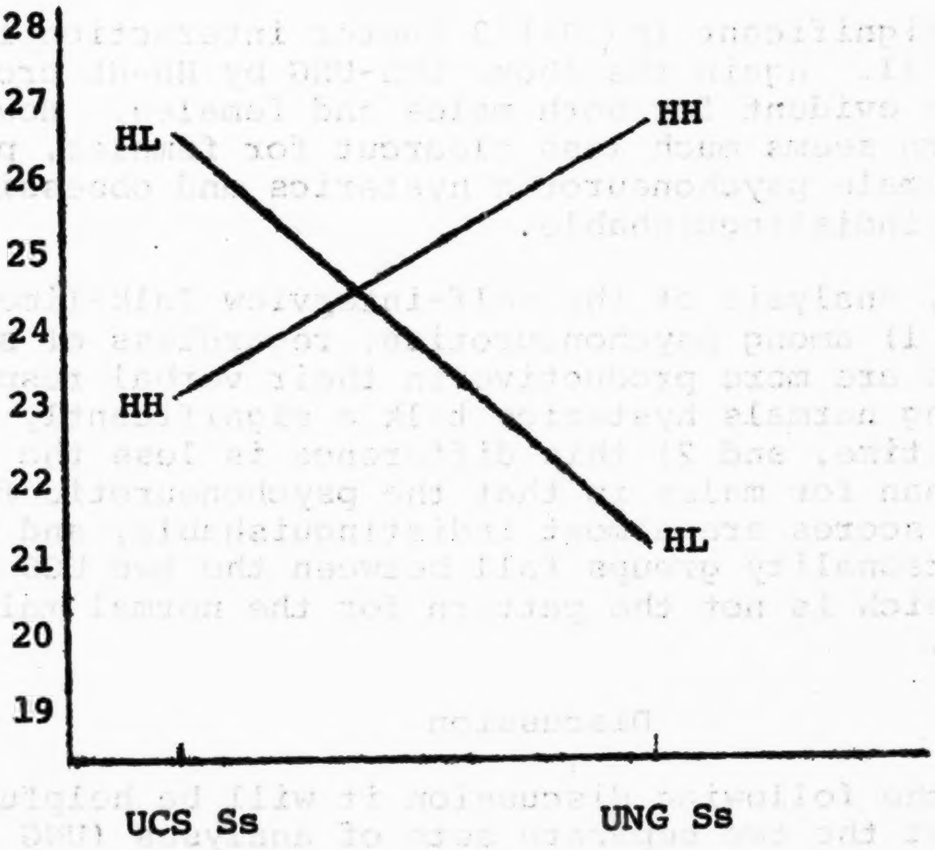
Thus, analysis of the self-interview Talk-Time scores show that 1) among psychoneurotics, regardless of sex, obsessives are more productive in their verbal responses; while among normals hysterics talk a significantly greater amount of time, and 2) this difference is less the case for females than for males in that the psychoneurotic females' Talk-Time scores are almost indistinguishable, and both UCS female personality groups fall between the two UCS male groups--which is not the pattern for the normal male and female Ss.

Discussion

For the following discussion it will be helpful to recall that the two separate sets of analyses (UNG and UNG vs UCS) considered three distinct pairs of Eysenck personality groups. The undergraduate normal sample included two pairs of Eysenck groups. The first pair included the "normal (UNG) obsessives" and "normal (UNG) hysterics." The second pair are the "normal (UNG) introverts" and "normal (UNG) extraverts." Finally, the counseling service (UCS) sample provided the pair of "UCS obsessives" and "UCS hysterics." A subtle distinction differentiates "UNG obsessives" from "UCS obsessives", and "UNG hysterics" from

Figure 12

Significant ($p<.05$) 2 Factor Interaction (UCS-UNG x HiHi-HiLo personality Groups) for the Talk-Time scores, expressed in minutes. (n = 34 in each UCS group, n = 24 in each UNG group).



"UCS hysterics." Both UNG and UCS groups have high Bendig E (neuroticism) scores, suggesting a high level of anxiety and some emotional problems for both. The UNG and UCS groups differ in that only the latter groups have publicly acknowledged psychoneurotic status by coming to the university counseling service for assistance. Hence the UCS groups have an additional factor of motivation for, or expectancy of, help with their personal problems which is absent for the UNG groups.

Experiencing

The major expectation of the study was that subject interview Experiencing would be related to Eysenck's two personality factors, neuroticism and extraversion-introversion, in combination rather than individually. Generally the results of the present study support this expectation. They further suggest that additional factors, other than Eysenck's two personality dimensions, need to be included in future theory and research--namely, sex of subject and need for or expectancy of therapeutic help (reflected by whether or not the subject is seeking psychotherapeutic assistance for his problems).

In both sets of EXP score analyses (UNG and UNG vs UCS) the three factor interaction was the only consistently significant effect. For the undergraduate normals this indicated that regarding Experiencing Eysenck's personality factors interact differently for males in contrast to females. Among males normal obsessives show the highest level of Experiencing in their self-interviews, while normal introverts show the lowest level. Among females, on the other hand, normal introverts showed greatest self-revelation, while normal obsessives showed the lowest level of EXP. Normal hysterics and normal extraverts were indistinguishable among females, while for males normal hysterics scored higher than normal extraverts.

It seems then, at least in relationship to Experiencing, sex is an important factor that needs to be considered along with Eysenck's personality factors. Relationships between Experiencing and Eysenck's factors tend to be reversed for the two sexes. For males, when high levels of anxiety are added to introversion, the effect is greater Experiencing; while for females the result is a depressed level of self-exploration. When introversion is combined with low levels of anxiety, minimal Experiencing results for males, while females show elevated self-revelation. The reason for these contrary patterns for the sexes is elusive to this author. But their existence seems to necessitate some revision of

Eysenck's theory incorporating the factor of sex, and further to suggest that findings in the literature may well be divergent depending on subjects' sex in a particular study.

A similarly unexpected finding emerged for Experiencing when UNG obsessives and hysterics were compared with UCS obsessives and hysterics. Theoretically these pairs of subjects should not differ since their scores on the operational measures of E and EI are virtually identical. Yet again the findings reveal the three factor interaction to be statistically significant. The interaction, however, seems to result primarily from the male subjects' scores. Among males, UCS hysterics attain a higher level of Experiencing than UCS obsessives; while UNG obsessives score higher on EXP than UNG hysterics. Further, the male UCS obsessive shows a markedly lower level of Experiencing than all other groups. Apparently only for males does the factor of psychoneurotic status (defined as coming to a counseling service for help with personal problems) interact with the hysteric-obsessive groups in determining the level of Experiencing shown in a self- interview situation. This interaction is also difficult to explain. Assuming the finding could be replicated, it argues again for including additional factors in Eysenck's system.

The factor of psychoneurotic status did not, however, of itself produce differences in Experiencing for the two groups, since the UCS-UNG main effect was not statistically significant. The scores nevertheless indicated that all UCS groups (male obsessives excepted) attained higher levels of Experiencing than their UNG counterparts. This trend, though not significant, seems sensible, indicating that when one seeks help for his problems he becomes more open to revealing himself in an interview situation.

For the UCS-UNG analysis only there was also a trend present for females of both samples to show higher levels of Experiencing than males. This finding, although not statistically clearcut nor found for the UNG analysis, is consistent with previous research reporting greater self-revelation on the part of females (Fuller, 1963; Boulware & Holmes, 1970).

Verbal Productivity or Talk-Time

Previous studies of the EXP Scale indicated that Experiencing ratings are positively correlated to the length of recorded sample being rated. To eliminate this source of confounding segments for the present study were all of standard length, i.e. each was 5 minutes long. A separate but similar factor present for this study was the total amount of time S talked during the entire self-interview task. These times varied markedly for the present subjects. Talk-Time was analysed primarily to determine whether verbal productivity in an interview situation is related to Eysenck's personality groups.

When the normal UNG Ss' scores were analysed no verbal productivity differences were obtained for Eysenck's four personality groups, either alone or in interaction with the sex factor. The only effect appearing for the normals was that UNG males talked significantly longer than UNG females in the self-interview, a finding inconsistent with the popular lore. However, this sex difference was not present when UCS obsessives and hysterics were compared with their UNG counterparts. In this comparison the three factor interaction instead was highly significant. Here the talk-time scores showed that, for both males and females, UCS obsessives talked more than UCS hysterics; while UNG hysterics talked more than UNG obsessives. The pattern was much less clearcut for females in that female UCS hysterics and obsessives were virtually indistinguishable.

Hence, for talk-time just as for Experiencing, indentical Eysenck personality groups behave differently depending on the presence or absence of the psychoneurotic status factor. When they are seeking therapeutic assistance obsessives talk more in a self-interview than hysterics; when they are not, hysterics talk more than obsessives.

Socioeconomic Status

Recent studies have reported this factor as one having important influence on relationships obtained for therapy and personality variables. The present findings revealed only one significant effect for the SE factor. The sex main effect showed that males of the present study came from significantly lower socioeconomic backgrounds than did females among the UNG sample. In the UNG-UCS analysis the only tendency present was that the normal undergraduates tended to come from homes of lower SE status than did the UCS clients. The latter finding is consistent with previous reports that psychiatric outpatients tend to come from higher socioeconomic levels. The prior finding regarding sex differences is likely a peculiarity of the particular Iowa sample. In any case, SE status was not related to Eysenck's personality groups for the present samples, either alone or in interaction with other factors.

Social Desirability

In the analysis of the Marlowe-Crowne scores for the normal, undergraduate sample the main effect for the Emotionality factor was highly significant. Low anxious subjects attained higher social desirability scores than high anxious subjects, regardless of extraversion-intorversion or the sex factor. This finding is consistent with the significant negative relationships reported in the literature between anxiety (emotionality or neuroticism) and social desirability (cf. Christie & Lindauer, pp. 202-216).

In both the UNG and UNG-UCS analyses the three factor interaction effect was significant at the .10 level. Among undergraudates, regardless of anxiety level, introverts (low EI) were higher in social desirability among males; while for females extraverts (high EI) showed more social desirability. This crossover effect was more dramatic for the high anxious subjects. This same pattern held for the UCS-UNG analysis. For females, hysterics had higher social desirability scores in both the UNG and UCS groups; while for males, obsessives obtained the higher scores. Hence, in the case of SD, the factor of psychoneurotic status did not alter the relationships obtained for the UNG groups.

Finally, in the UCS-UNG analysis the sex main effect was also statistically significant, showing that females in both samples obtained higher social desirability scores than did males. That is, highly anxious females, whether clients or not, place higher importance than highly anxious males on the expectations of others regarding their behavior.

Response Acquiescence

Both sets of analyses of the Couch-Keniston scores revealed similar findings. High anxious (emotional) subjects obtained higher response acquiescence scores than low anxious subjects. Extraverted subjects receive higher RA scores than introverts.

In both analyses the three factor interaction was statistically significant. Among undergraduates, the ordering of the personality groups was the same for both sexes: hysterics higher than obsessives, higher than extraverts, higher than introverts. However, for males the addition of introversion to low anxiety tended to drop considerably the RA scores obtained; while for females combining extraversion with high anxiwty tended to elevate sharply the level of acquiescence obtained. In the UCS-UNG comparison the three factor interaction showed a similar pattern for males, in that hysterics were higher in RA than obsessives. But for females, addition of the psychoneurotic status factor reversed the pattern obtained for normals--for UCS females, obsessives received the higher response acquiescence scores. Generally, these findings suggest that subjects receiving high scores on both of Eysenck's personality factors show the greatest tendency to acquiesce, while subjects low on both show the least.

Finally, the UCS-UNG main effect was highly significant in the UCS-UNG comparison, showing that UCS hysterics and obsessives obtained higher response acquiescence scores than UNG hysterics and obsessives. Apparently the factor of seeking therapeutic assistance makes it more likely for an hysteric or obsessive subject to acquiesce in self-reports, and reflects perhaps a more general openness or suggestibility for the UCS subjects.

Relationship Inventory Scores for Ideal Therapist

All subjects filled out Barrett-Lennard questionnaires on their "ideal therapist.' These scores reflect the extent to which a subject considers important or expects Rogers' "conditions" or relationship qualities of his therapist in psychotherapy. For the normal UNG sample, analysis of the RI scores revealed only one statistically significant effect, the main effect for Emotionality. This indicated that low anxious subjects attributed significantly higher levels of empathic understanding, positive regard, and congruence to their ideal therapist than did high anxious subjects. While hysterics and obsessives showed no differences in RI scores among the normal sample, for the psychoneurotic UCS sample hysterics described their ideal therapist as having higher levels of Rogerian conditions than did obsessives. Thus, the additional factor of psychoneurotic status made relationship factors more crucial in an ideal therapist for hysteric subjects, but had no effect for obsessive subjects.

Finally, the sex main effect was significant for the UCS-UNG analysis. Females, regardless of sample or personality group, described their ideal therapist as significantly higher in empathy, regard, and congruence than males. The upshot seems to be that highly anxious females more than highly anxious males, and high more than low anxious subjects tend to consider relationship factors in a potential therapist as more crucial. Also hysterics more than obsessives consider them more important, but only when hysterics have admitted their need for help by applying to a psychotherapy treatment agency.

Conclusions

An important conclusion of the present study is that an operational measure of Eysenck's trait personality constructs (the Bendig scale) separated existing normal and psychoneurotic samples in a manner highly consistent with Eysenck's theory. By combining the neuroticism (emotionality) and extraversion-introversion factors, it was relatively easy to select subjects from a sample of 518 undergraduate normals who filled all four personality group cells. At least in university undergraduate populations the entire range of both the neuroticism and extraversion-introversion dimensions seem to be present and operative. Likewise, a sample of 93 clients applying to a university counseling service for help with personal problems revealed, as theory dictates, few subjects with low neuroticism (emotionality) scores. Only 10 of the 93 subjects had Emotionality scores below the mean reported by Bendig for his normative sample. The remaining 83 clients were easily assignable to either the hysteric or obsessive cells. These Bendig findings represent further evidence for the construct validity of Eysenck's factors.

The findings for the Experiencing Scale scores of the present study suggest that a self-interview condition is significantly different, in terms of level of Experiencing elicited, from the usual dyadic therapy session. The interjudge reliabilities of the self-interview EXP ratings of this study are considerably lower in value than those found for previous studies of live therapy sessions. The major consideration seems to be the more restricted range of EXP scores obtained for the self-interviews. Further, comparison of the level of EXP scores obtained for the UCS self-interview subjects of this study with those obtained for previously studied live-therapy neurotics show the latter neurotics to receive higher scores for self-revelation. The most frequently obtained EXP score of the present UCS clients was at Stage 2, with a mean score of 2.32 for these subjects. On the other hand, previously studied live-therapy neurotics have obtained mean EXP scores ranging from 2.3 to 2.7. Apparently the highest mean score obtained by psychoneurotics in the self-interview situation is at the lower end of the range of EXP scores found for neurotics in live, dyadic therapy sessions. The self-interview situation, therefore, seems to attenuate psychoneurotics' interview Experiencing behavior, so that subjects show less variability and lower levels in the EXP scores they obtain. This futher implies that an important source of variance in client self-report may be eliminated when the therapist is not present in the interview situation, and also cautions against cavalier use of self-interview tasks as analogues of the dyadic psychotherapy session.

Finally, the findings of the present study seem to represent good evidence that interactions of Eysenck's two personality factors with each other, and with the additional sex and psychoneurotic status factors account for variance in behavior that cannot be explained by either personality factor alone. For the 12 separate ANOVAs for the UNG and UNG-UCS comparisons reported above, in five cases the three factor interaction effect was significant at .05 or better, and in two cases at .10. That is, two thirds of the time for these analyses, Eysenck's personality groups interacted with each other and in combination with either the sex or psychoneurotic status factors in producing differences in the dependent variables of the study.

These results seem to argue rather cogently for considering the factorial combinations of neuroticism and extraversion-introversion in subsequent studies of Eysenck's theory. Similarly, the fact that previous studies of the neuroticism and extraversion-introversion factors have reported contradictory results is perhaps explainable in that either one of the scales was ignored in a particular study or, if the two scales were used, they were not combined in factorial designs. Finally, the significant interaction of the personality factors with sex in some cases, in others with psychoneurotic status (coming to an outpatient agency for help with personal problems) suggest that Eysenck's present theoretical statements need to be expanded to include these additional factors in his network.

III. Conclusions and Recommendations

The findings of the present research program are encouraging in regard to further applications of the Experiencing Scale in counseling and psychotherapy research. Because of accumulated methodological research for the Scale it is now possible to make sampling, rating and other important decisions for a particular study based upon sound empirical data. In addition, the Experiencing Scale Training Manual is currently in process of publication by the Bureau of Audio Visual Research at the University of Wisconsin, and should be easily available to other researchers later this year, together with copies of the tape-recorded training segments.

Research applying the scale to clinical and normal populations has also been encouraging, with the findings offering limited validating evidence for the Experiencing construct. The most clearcut findings to date are the following. 1) Gross nosological groups of patients can be easily differentiated in terms of the level of Experiencing patients manifest in therapy interviews. During therapy psychoneurotics talk at a significantly higher level of Experiencing than either schizophrenic or normal subjects. Normals and schizophrenics are indistinguishable in terms of the level of Experiencing they manifest. 2) When one looks at individual therapy sessions, clearly different patterns of Experiencing over the 50-minute hour emerge for psychoneurotics, schizophrenics and normals. Neurotics show an increasing monotonic function of Experiencing from early to late in the hour; schizophrenics show a saw-tooth pattern; and normals reveal an initial rise then progressive decline to the end of the hour. 3) Level of Experiencing is clearly related to independent more-successful vs less-successful differentiations of psychoneurotic and schizophrenic therapy cases. More-successful patients (as determined by various psychometric and other objective outcome indices) show a consistently higher level of Experiencing at all points over the total interviews sequence than do less-successful cases. Currently this finding is not clearly interpretable, since a constellation of initial patient characteristics, as well as measures of Rogers' therapist relationship qualities, are also related to both Experiencing and more-successful outcome. 4) More-successful cases cannot be differentiated from less-successful ones by means of the slope or shape of Experiencing they show over the entire therapy interaction. Differential functions or patterns of change in Experiencing over the course of therapy are not present for more-successful vs less-successful cases. Currently, this negative finding needs to be qualified in regard to the boundary conditions of previous studies--i.e. random sampling of a 2-4 minute segment from each of the first thirty therapy sessions. Whether systematic sampling procedures, considering specific patient content themes or specific patient-therapist interactional themes, might reflect differential change for more-successful cases is a matter for future research. 5) Regardless of case outcome, there seems to be a characteristic curve or function of Experiencing, found for both schizophrenics and normals, for the first thirty therapy interviews. Statistically the function takes an inverted cubic form. This indicates a progressive drop in Experiencing from the initial to approximately the fifteenth interview, followed by a rise and subsequent fall in Experiencing to the thirtieth session. More generally the function seems to suggest that there are regular rises and falls, peaks and troughs, in Experiencing over the entire course of therapy. An increasing or decreasing monotonic function for Experiencing is not found for patients over the first thirty therapy interviews.

The upshot seems to be that the Experiencing Scale is tapping a patient expressive trait dimension which is operative from the initiation of therapy. Although this self-expressive language trait vacillates in activity over time and shows reliable change over a particular interview, it is the relatively stable level of the trait dimension over time that is related to measures of therapist behavior and to outcome criteria. That is, the scale seems sensitive to patient state factors (since it shows reliable change within an individual session and shows a reliable function over the entire therapy sequence for all patients); but these state or change aspects of Experiencing seem unrelated to other meaningful dimensions or aspects of therapy, such as case outcome or therapist characteristics.

The basic deficiency of the Experiencing construct seems to be that its theoretical proponents have not explicitly incorporated other relevant patient individual difference factors into the network. Although evidence shows that more-successful outcome is associated with higher levels of Experiencing, other dimensions seem co-related and clinically relevant. Socioeconomic class and verbal facility, at least, have confounded previous results, and their place in the theoretical framework needs to be clarified.

It seems likely, further, that within the gross nosological groups different trait and defense systems are related to Experiencing. Although the findings are far from clearcut, the present research supported this contention, at least for obsessive and hysteric personality groups. In this regard, moreover, it seems feasible that different ways in which patients manifest low levels of Experiencing in therapy may provide relevant clues for differentiating homogeneous patient groups for whom differential treatments can be designed. That is, measures of different modes of "resistance" might provide important complementary data to Experiencing ratings, in terms not only of differential diagnosis, but also of differential therapist technique and differential outcome. In traditional parlance resistances are the major roadblocks to Experiencing or self-exploration and, hence, seem highly relevant to subsequent treatment and outcome considerations. Finally, measures of resistance patterns would permit not only the possibility of reliable differentiation of patient groups, but further would provide assessment indices for relevant therapeutic change for the respective groups--i.e. provide relevant in-therapy outcome assessment.

In summary, evidence for the Experiencing construct is good and suggests that further exploration is in order. On the other hand, the same evidence calls for some modification of the Experiencing construct emphasizing its apparent trait (rather than state) nature, and for some expansion of the construct including explicit formulations about correlated patient individual difference factors, defensive processes, and resistances.

IV. Supplementary and Appendix Materials

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B. Appendixes

The Experiencing Scale

The general definition of each stage is followed by an outline of the major subcategories and criteria for each.

Stage One

The chief characteristic of this stage the content or manner of expression is impersonal. In some cases content may be intrinsically impersonal, being very general, superficial, or simply a narrative of events with no personal referent established. In other cases it is the speaker's involvement that is impersonal so that he reveals nothing private or tender about himself and the remarks could equally well be about a stranger or an object.

1. The content is not about the speaker. The speaker may tell a story or describe other people or events in which he is not involved. It may be a generalized or detached account of ideas. In each case there is nothing to make the content personal.

2. The content is such the speaker could be identified with it in some way but this association is not made clear. The speaker may in passing refer to himself, but these references do not function to establish or clarify his involvement. If the first person is used, the pronouns function only to define the speaker as an object, spectator, or incidental participant. The focus remains on the events and the speaker's role is unelaborated (e.g., as I was walking down the street I saw --, I read a book that --, I put the lid on the book --, he stepped on my toe --, etc.). The speaker does not supply his attitudes, feelings, or reactions, and treats himself as an object or in such a remote way that the story could equally well be about someone else. His manner of expression might be remote, matter-of-fact, or offhand as in superficial social chit-chat, or have a mechanical or rehearsed quality as if the story could be told to anyone.

3. Sate one is also rated either for a terse, unelaborated, or unexplained refusal on the part of the speaker to participate in an interaction or for an unexplained avoidance of or squelching of an interaction. Involvement is kept at an absolute minimum and there are no spontaneous comments made about the situation.

Stage Two

There is an explicit association established between the speaker and the content, either in that he is the central character involved in the narrative, or because the personal relevance of the content is made clear. The speaker's involvement, however, does not go beyond the specific content. All comments, associations, reactions, and remarks function to get the story or point across but do not refer to or define his feelings.

1. The content is a narrative of events in which the speaker is obviously involved in some personal way but his remarks simply establish that the content is personally important and make no reference to the explicit quality or degree of involvement. All remarks and associations refer to facets of the narrative external to the speaker (other people, the events, objects, or just the speaker's actions) and do not include his inner reactions or perspective. The narrative may be elaborated to include details of the speaker's thought, opinions, wishes, etc., that describe him intellectually, but these details are not related to his feelings.

2. If the events narrated are impersonal the speaker must explicitly establish that the content is meaningful for him (e.g., expression of interest in or clear evaluation of the event). These remarks only establish that the content is important, but make no explicit reference to the quality or degree of this involvement.

3. Self-characterization or self-descriptions are at stage two if they are very abstract, generalized, or intellectualized and make no clear reference to the speaker's feelings or private phenomenology. The segment may describe the speaker's ideas, attitude, opinions, wishes, preferences, aspirations, talents, capacities, etc., that function to describe him from an external or peripheral perspective.

4. The speaker's feelings, reactions, etc., may be quite apparent or implicit (either because he is emotionally aroused or because the content is the type that ordinarily would be personally significant) but these feelings are not referred to directly, are not differentiated from the narrative, or are not personally owned. At stage two the speaker makes his feelings or experiences very abstract, or turn them into objects or events so that he seems to be describing them from afar as if they were in the general

situations or primarily the responsibility of another person. The speaker may also refer to his ideas and thoughts as if they were feelings (I feel that I am a good farmer; I feel that people should be more considerate) but at stage two the words "I think" could easily be substituded for "I feel" without changing the meaning significantly.

Stage Three

The speaker's focus is primarily on telling the story or describing himself in external or behavioral terms, but he goes beyond the content to comment about his feelings or private experiences. These remarks are limited to the events or situation and function to give the narrative a personal touch without specifically describing the speaker more personally or comprehensively. Also at three are instances where self-description is restricted to a specific situation.

1. The content is a narrative of events or description of some aspect of the speaker's environment (past, present or future) with parenthetical remarks

   a. About the speaker's feelings at the time of the event or in retrospect about the event (as opposed to a description of actions, capacities, ideas, opinions or moral judgments);

   b. Describing the speaker's state of awareness at the time of the events, (i.e., details of motives, consciousness, private perceptions or assumptions; e.g., I did it even though I knew at the time that I didn't want to);

   c. That clarify the personal significance or implications of the situation by relating it in detail to the speaker's private experiences.

2. Self descriptions are at stage three when they are limited to fairly superficial aspects of the speaker's life style or role behavior, or characterize his feelings and reactions only in limited or behaviorally elaborated terms (i.e., what he does or what happens when he gets angry as opposed to what he thinks and feels). At stage three personal remarks function primarily to describe a situation richly or to describe the speaker in one situation but do not clarify his personal reactions in a more general context.

3. If asked a direct question about his feelings the speaker must go beyond a simple yes or no response to elaborate enough that the reference to the feeling would be clear

even if the interviewer's remarks were not available. Unelaborated yes or no responses to interviewer questions about feelings are stage two or one, depending on the amount of personal reference.

4. Descriptions of "private" experiences such as dreams, fantasies, or free associations should be treated as narratives. They are at stage three only if feelings are specifically referred to. If associations simply describe or explain details of the narrative or setting or trace or expand ideas and thoughts, then stage two is appropriate.

Stage Four

At stage four the speaker clearly describes his feelings and refers to his personal, internal perspective or his feelings about himself. As a result he communicates what it is like to be him. A specific situation may provide the starting point, but the speaker goes beyond it to focus in detail on his personal perspective and feelings. These internally anchored self-references are presented and described, but do not serve as the basis for systematic self-examination or formulations.

1. If a specific situation is the starting point, the self-references must either go beyond it:

    a. to show what the speaker is like more generally or more personally (i.e., describe his feelings in detail, refer to feelings as they occur in a range of situations, provide further personal reactions to specific feelings, relate the reactions to his self-image). The remarks can either be in the form of reactions to ongoing events, or immediate reactions to past events. Externally or behaviorally elaborated self-descriptions, or moral evaluations of the self are not sufficient for four.

    b. to tell a story completely from a personal point of view with many details of feelings, reactions, assumptions, etc., so that what emerges beyond a narrative is a clear and detailed picture of what it is like for the speaker to have the feelings he does at that moment.

2. The speaker may (without starting from a specific situation) talk in general about himself in terms of his feelings and personality, assumptions, motives, goals and

private perceptions. By revealing these internal parts of himself the speaker gives a fairly detailed picture of one or more of his states of being without making any systematic efforts to examine or analyze the material that comes up. Details given must be more personal than an account of behavior, actions, opinions or thoughts.

Stage Five

At stage five the speaker is engaged in the purposeful exploration or elaboration of his feelings. There are two components to this process: the speaker must pose or define a problem or proposition about himself explicitly in terms of his feelings and it must be explored or elaborated in some personal way. The problem or proposition may involve the specific origin, sequence, or implications of feelings, or relate feelings to other private processes. The exploration or elaboration must be clearly related to the problem or proposition and must contain some inner reference so that it can potentially function to expand or clarify the speaker's awareness of how he works inside.

Both one and two below must be present for stage five to be rated. If one (problem or proposition) is presented very strongly or clearly, then it is not essential that the elaboration be extensive or consistently internal, provided that it's thematic relevance is clear. If the internal anchorage of the problem or proposition is weaker (e.g., as in speculations about external causes of feelings or the content or temporal sequence of feelings) then the exploration or elaboration part must have extensive inward referents so that it is clear at the speaker's focus is on expanding his self-awareness rather than on describing an external situation or justifying his behavior and reactions.

1. A stage five problem or hypothesis about the self must be primarily oriented to feelings, private reactions, or assumptions basic to the self image. It can be defined in different ways:
    a. a feeling, reaction, or inner process, and in some cases a behavior pattern, can be defined as problematic in and of itself or seem to conflict with other feelingsor aspects of the self;
    b. the speaker may wonder whether or to what extent he has a specific feeling (e.g., not what do I feel? which would be three or four, but do I really feel angry?);
    c. the problem or proposition can be defined in terms of the personal implications, relationships, and inner ramifications of a feeling,

including its origins or causes, its place in a temporal sequence of feelings and inner events, its mode of expression, or its personal and private implications;

d. feelings, reactions and internal processes may be compared in some way.

2. All problems or propositions about the self must be explored or elaborated with inner referents that:

a. provide examples or illustrations of how the problem or propositon exists or operates within different settings or at different times (including a fully elaborated restatement);

b. relate the problem or proposition to detail to other internal processes and reactions; or

c. establish hypotheses, speculations, or analogies that can clarify the nature or private implications of the central problem, its causes, or ramifications.

3. The speaker's attempts to explore and work with the interviewer's questions or interpretations about feelings are not five unless the speaker puts the interviewer's ideas into his own words and adds ideas or explorations of his own.

Stage Six

The speaker's feelings are readily available to him and are immediately and clearly used as an integral part of his description or conclusions about his inner workings in such a way that he achieves a new level of self-understanding. The feelings involved could either be reactions to an immediate situation or immediately experienced feelings about past or future events. What is clarified are the relationships among feelings, the causes for or implications of feelings, or the significance of specific feelings from other aspects of private experience (the self-image, private perception, motivations, etc.). What the speaker says about himself goes beyond pure description and demonstrates his facility for evolving a privately meaningful structure from his experience or testing privately-meaningful formulations against his experience in such a way that ambiguities are resolved.

1. The content may be a detailed explanation of the relationship between two feelings (their causal relationship, how they may conflict or complement each other), provided that it goes beyond the simple temporal or sequential

relationship. Thus the workings, the how or why of the relationship or sequence must be immediately apparent and described with internal reference.

2. The content may be a detailed description of the relationship between one feeling and other aspects of the person's private experience such as his self image, private perception, motives, etc., which function as an interpretation of the of the personal basis of the speaker's feelings. Interpretations of actions, attitudes, and events that are not internally anchored are not six.

3. If the content refers to the relationship between feelings and the situations in which the feelings arise, or the relationship between feelings and more external or superficial aspects of the self, the detailed elaboration must provide references to the speaker's private experience that make the relationship of the inner processes and outer events very clear.

4. Simple reference to changes in the self or feelings, or descriptions of past experiences where the speaker achieved understanding are not six unless they are elaborated extensively to show how change came about, and what the private details of the formulation are. Similarly the speaker's positive or negative responses to the interviewer's formulations or interpretations are not six unless they provide immediate and internally anchored confirmation.

5. Any fully expanded use of an analogy that refers to the speaker's dynamics is six provided the private implications are made clear and go beyond the simple description of the simple description of the feelings-quality to communicate how the feeling works.

6. Occasionally at stage six there may be specific indications that a personally significant formulation has occurred, though not necessarily within the moments recorded. Reference may be made to a momentary "a-hah" experience, as when something that has been vague before suddenly "opens up" so that many details can be brought into a new perspective. To be rated six such an experience must be elaborated in detail so that the specific nature of the new content, or the newly-understood relationships between feelings and behavior is explained.

Stage Seven

At stage seven the speaker communicates a full and easy awareness of his immediately present feelings and internal processes. He can move to one inner reference to another, altering and modifying his conceptions of his self, his feelings, private reactions to his thoughts or actions in terms of their immediately felt nuances that occur in the present experiential events so that each new level of self awareness functions as a spring board for further exploration.

1. The speaker may start with a problem within himself, explore it and reach some interiorly anchored conclusion that he then applies to a number of other situations, or to other problems. He may also arrive at several related solutions to a single problem and integrate them in some way. Any self-analysis is followed by a more comprehensive or more extensive synthesis.

2. The speaker may refer to several different formulations about himself (each of which meet the requirements for stage six) and then go on to integrate them or reduce them to a more basic formulation.

3. The speaker may start with one stage six-type conclusion about himself and apply or use it in talking about a wide range of situations (each with inner referents established) so that he shows how the general principle applies to a rather wide area of his experience (e.g., past, present, future situations or different kinds of situations freely elaborated).

4. All formulations about the self at stage seven that provide the links between elaboration or more descriptive association must meet the criteria for stage six in that feelings or inner events are central to them. What differentiates stage seven from stage six is that these conclusions can be easily applied to a range of inner events or that they can give rise to a series of new and more comprehensive insights.

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